Digitized by the Internet Archive
in 2017 with funding from
The National Endowment for the Humanities and the Arcadia Fund

https://archive.org/details/virginiamedical117unse_0

UC San Francisco LIBRARY
UNIVERSITY OF CALIFORNIA · UNIVERSITY OF CALIFORNIA

CURRENT
JNLS
W1
VI
799J

Virginia Medical
UCSF LIBRARY
Received on: 02-01-90

IRGINIA MEDICAL

JAN
1990

Award Winning Publication of The Medical Society of Virginia

When Disability Puts Your Practice on Hold...

You Can Depend on the Medical Society of Virginia Sponsored Disability Income Plan

If you became disabled, how would you obtain money to replace your lost income? How would you pay your ordinary day-to-day expenses? You can depend on the MSV sponsored Disability Income Plan to help meet your financial needs!

Highlights

- Up to **$10,000** Monthly Benefits
- Choice of a **Long Term Plan** or a **Short Term Plan**
- Choice of **4 Waiting Periods**
- Liberal definition of disability
- **Affordable** group rates

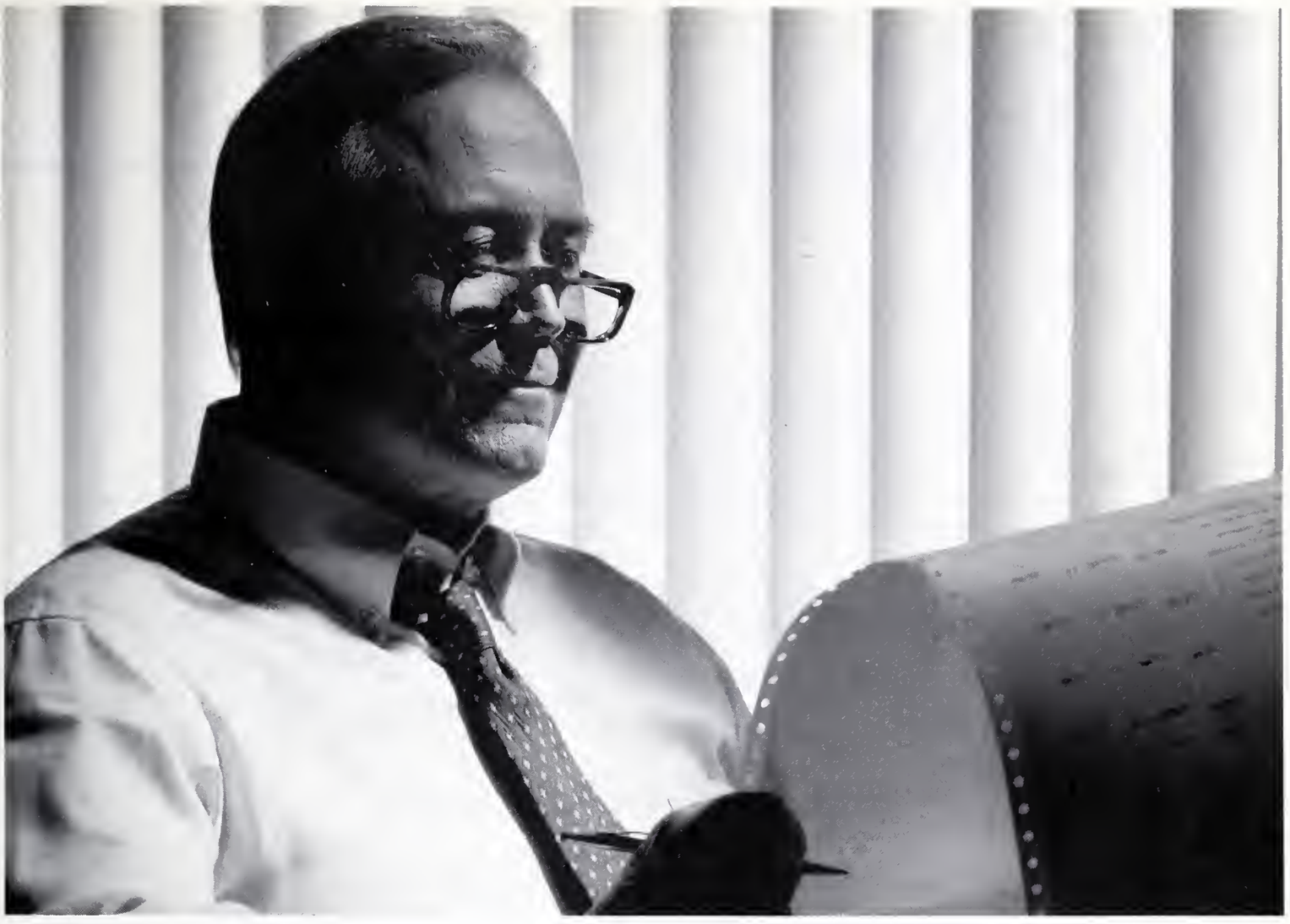
For more information about the **MSV** sponsored **Disability Income Plan**, including all costs, terms and limitations, please write the insurance administrator, John P. Pearl & Associates, Ltd., or call Toll-Free in Virginia at 800-572-2211. Local residents, call (804) 282-9600.

Administered By

John P. Pearl & Associates, Ltd.
6620 W. Broad St., Suite 300
Richmond, VA 23230-1724

Underwritten By

Life Insurance Company of North America



Three financial reasons why practices choose the ACCLAIM™ Medical System

There are many compelling reasons to automate with the ACCLAIM Medical System. Here are three important benefits our customers have taken the time to write to us about:

1 Improved Cash Flow

"We have seen dramatic improvements in the efficiency of filing insurance claims and tracking accounts. We've also seen substantial improvement in our accounts receivable."

Susan Shaffer, Office Manager
Single Physician Practice

2 Increased Productivity

"The system is easy to use, straightforward in its commands and simplifies medical office management beyond belief."

Judy Greenburg, Office Manager
Four Physician Practice

3 Financial Control

"Sentient's ACCLAIM system has improved our collections by 100% and has provided reliable data on which to base practice management decisions."

Frank J. Mayo, M.D., Pulmonologist

Sentient Systems offers total solutions. Hardware (IBM® and compatible), software, installation, data conversion, training, support and service are a part of every system. We provide the highest quality medical system available today. Just ask our customers.

For a free consultation call Sentient at:

301-929-7600
800-247-9419

ACCLAIM is a trademark of Sentient Systems, Inc.
IBM is a registered trademark of International Business Machines Corporation.

I'm interested. Please...

☐ Rush me an information portfolio.
☐ Call to set up a free office analysis.

I plan to purchase within:

1 month ___ 2 months ___ 3-6 months ___

Practice Name

Address

City State Zip

Telephone Best time to call

Return to: Sentient Systems
10410 North Kensington Parkway
Kensington, MD 20895-2939

SENTIENT
SYSTEMS

THE MEDICAL COMPUTING LEADER

VIRGINIA MEDICAL

January 1990, Volume 117, Number 1

© 1990—The Medical Society of Virginia

AT THE ANNUAL MEETING

On the cover **Dr. Lewis W. Bridgforth (right) looks over the award presented to him by Dr. J. Thomas Hulvey (left).** Story on page 18.

10 **Actions of the House of Delegates, an Illustrated Report**
10 **Reference Committee One: Education/Interprofessional Relations**
15 **Reference Committee Two: Legislation/Regulation**
27 **Reference Committee Three: Internal Affairs**
11 **The New Leadership**
18 **Winners:** Dr. Bridgforth wins the Community Service Award
30 **Fifty-Year Club**
31 **Dr. Barney takes charge**
32 **Presidential Address** J. Thomas Hulvey

EDITORIAL

31 **Hooray and Hallelujah** E. L. Kendig, Jr.

6 **Letters to the Editor** Vivian Petty, Timothy A. Mjos, and William M. Bickers
28 **Medical Society of Virginia Officers 1989–1990**
34 **Meetings about Medicine**
36 **Advice to Authors**
42 **New MSV Members**
44 **Classified Advertisements**

Cover photograph by Taylor Dabney

Editor Edwin L. Kendig, Jr., MD
Associate Editors Richard G. Lester, MD; Duncan S. Owen, Jr., MD; John A. Owen, Jr., MD
Editorial Board H. C. Alexander III, MD; Raymond S. Brown, MD; Henry S. Campell, MD; C. Barrie Cook, MD; Eloise C. Haun, MD; Walter Lawrence, Jr., MD; Lockhart B. McGuire, MD; Robert Edgar Mitchell, Jr., MD
Executive Editor Ann Gray Assistant, Sandra McKinnon
Business Manager James L. Moore, Jr.

DISCLAIMER: Advertisements in VIRGINIA MEDICAL for products, services, courses and symposia are published with a "buyer beware" understanding. The Publisher, the Editor and members of the Editorial Board do not imply warranty of products, nor endorsement of offered educational material.

VIRGINIA MEDICAL (ISSN 0146-3616) is the monthly publication of The Medical Society of Virginia. Second-class postage paid at Richmond, Virginia. Yearly subscription rate: $24 domestic, $30 foreign; single copies, $3. VIRGINIA MEDICAL does not hold itself responsible for statements made by any contributor. The publisher reserves the right to reject any advertisement. For information on the preparation of articles, write to the Executive Editor for "Advice to Authors," or call (804) 353-2721. POSTMASTER: Send address changes to VIRGINIA MEDICAL, 4205 Dover Road, Richmond VA 23221.

When we reduce our malpractice rates...

...our promise continues...

and our insureds will save about

$5,000,000

Our malpractice rates are going down.

As the number of malpractice claims against physicians has declined nationwide the cost of insuring against those claims has declined. To keep our rates in line with the experience of our insureds in Virginia we have filed an application with the State Corporation Commission to substantially reduce our rates.

When our rate reduction is approved our insureds will pay substantially lower premiums. We anticipate the savings will be likewise substantial — about $5,000,000 in 1990.

This rate reduction is a further demonstration of our promise to work for our insureds. Last year we demonstrated our commitment to that promise by distributing $2,100,000 in equity return checks to physicians who were policyholders during the past three years.

Since The Reciprocal was founded a decade ago, we have concentrated on combining active risk management with prudent fiscal policy to give our insureds the insurance they need. A basic premise of our way of doing business is that all profits on our physicians' business, both from underwriting and investments, would be shared over time with our insured physicians.

Our policyholders are not only customers, they're investors in The Reciprocal. We're the subscriber-owned company that promises to work for our insureds. It's a promise they bank on.

To learn more about how you can invest your insurance premiums in The Reciprocal call us today.

The Virginia Insurance Reciprocal

4200 Innslake Drive
Glen Allen, Virginia 23060
Toll free: 1 800 284-TVIR — In Richmond: 747-8600

LETTERS

Health forum for teen-agers coming in March

The Medical Society of Virginia and Auxiliary are joining together to sponsor a program titled "Our Youth, Our Future" in Richmond on Tuesday, March 20. The Richmond Centre at the 6th Street Marketplace downtown will be the setting for the all-day program, which will be an Adolescent Health Forum for Virginia's teen-agers; 1,500 to 2,000 ninth to twelfth grade students at schools over the state are to be invited to attend. Lunch and snacks will be provided. Mrs. Eileen Thomas, Portsmouth, is serving with me as cochairman.

The faculty will be composed of physicians, psychologists, well-known sports figures, and other role models and inspirational speakers. Their overall theme will be one of building self-esteem, encouraging the students to live healthy lifestyles and building decision-making skills.

Teenage morbidity and mortality rates have increased 11% in the last 20 years, according to an AMA white paper. There seem to be five contributing categories: sexuality, alcohol/drug abuse, emotional disorders, abuse/victimization, and violence/crime. Poor self-esteem is the common thread running through all these areas. The program will serve to focus on coping with the complexities of maturing but will also affirm the many positive choices these young people are making.

Vivian Petty (Mrs. Carroll T.)
President,
Medical Society of Virginia Auxiliary
6 West Glenbrooke Circle, Richmond VA 23229

A severe critic reveals his identity

A recent editorial refers to a reader who, in his response to the recent Physician Opinion Survey, described the journal as "poor in literary or scientific merit."[1,2] That reader is I.

You asked, "Where were you when we needed you?" I am going to tell you. I was licking my wounds over the manuscripts rejected by your editorial staff. The last rejection was one entitled, "Robert Burns," a light, fanciful, obstetrical history, which would have been of considerable interest to obstetricians, and

RICHMOND ACADEMY OF MEDICINE
AUXILIARY FOUNDATION, INC.

1990 Antiques Show & Sale

SCIENCE MUSEUM OF VIRGINIA
2500 WEST BROAD STREET
RICHMOND, VIRGINIA 23220
(off Exit 14 from I-64/95)

February 8-11, 1990

THURSDAY, PATRONS' RECEPTION AND PREVIEW SALE, 7 p.m.
FRIDAY LECTURER: Deanne D. Levison
BENEFIT LUNCHEON: "AMERICAN INTERIORS: DECORATIVE ASPECTS OF FURNITURE AND FURNISHINGS", 11 a.m.
WINE AND CHEESE PARTY: "Southern Furniture: Comparison and Contrast with its Northern Counterparts," 8 p.m.
SUNDAY LECTURER: James W. Whitehead
"Reeves Collection and its Collectors . . . a Celebration of the Bicentennial Era of the America-China Trade," 2 p.m.
SHOW HOURS
FRIDAY AND SATURDAY, 11 a.m.-8 p.m **SUNDAY,** noon-5 p.m.
Tickets: 510 Greene Ridge Rd., Richmond, VA 23229 · General Admission—$5 · Information: 804-784-3696

even more interesting to those lighthearted ones who occasionally like an injection of humor into their scientific journals. Your editorial staff found it had no wit, no humor, and they could not fathom its value to a journal which proposes to be scientific.

During the long days of Pierce Rucker and Harry Warthan, I never suffered a rejection in over 15 contributions I made to the journal.

In conclusion, I would respectfully suggest that your editorial staff is somewhat lacking in humor, the publication lacks eclat. It is dull, flat, uninspired, and indicates an almost complete unawareness to classical references. Worst of all, it has no wit.

I write in the best of good spirit and good wishes for VIRGINIA MEDICAL.

William M. Bickers, MD

12401 Gayton Road, #128
Richmond VA 23233

1. Comments from the Physicians Opinion Survey. Va Med 1989;116:407
2. Kendig ELjr. Commentary. Va Med 1989;116:441

The Editor replies: At present, each article submitted to this journal is reviewed by at least two physicians, one of whom is a member of the same medical specialty as the author. If any reviewer shows any inclination toward publication, we try to suggest ways by which this can be accomplished. As I recall, the article, "Robert Burns," was indeed light and fanciful; the reviewers felt it worthy of publication but unfortunately not suitable for a medical journal.

When Dr. Bickers characterized the journal as without wit, dull, flat, and uninspired, I am sure he was not referring to the February 1988 issue, in which his text on liability litigation was the lead article[1] and was the subject of a special cover, printed in 4-color.

We would like to publish Dr. Bickers' work; most of the time, we will.

1. Bickers WM. The joys of liability litigation. Va Med 1988;115:68-70.

Article on contract problems with HMO strikes a chord

I read with interest the article by Dr. Clifton L. Peay in the November issue of VIRGINIA MEDICAL[1] in regards to his contractual problems with an HMO. It is interesting to see that the contagious HMO disease, which began in Minnesota in the early Seventies and which stimulated my migration to the Northern Neck of Virginia to practice, is infiltrating the metropolitan areas of the State of Virginia. It is my point of view from reviewing with colleagues in Minnesota that out of the fifteen HMOs in that state, only one has been economically viable. It is to the point where the largest HMO in Minnesota reimburses physicians for the care of their patients at less percentage than Medicaid. Again, this represents big business intervention into

Want an Excellent Site for an ACC in Virginia? We Know How to Find It.

Walk-in, primary care medical centers continue as growth leaders in the health care field. And there are excellent sites awaiting development in Virginia.

OUR SPECIALTY: Ambulatory care center start-ups. Detailed feasibility studies, site selection, financial forecasts, marketing support. Complete turn-key, or help only when and where you need it. And reasonable fees.

ACCs: Attractive lifestyle, low-risk investment. More information: Richard A. Reavis, M.D., medical director, Joshua Hartford, president.

ACCeSS, Inc.
100 Europa Drive, Suite 360
Chapel Hill, NC 27514
1-800-447-4276

Malpractice

How To Buy Medical Malpractice Insurance And Save Your Money

Buying malpractice insurance direct gets you one quote, one policy and no options.

Save your time and your money.

Clements & Company will compare policies and compete premiums. We know the markets and we've got the sources. We're independent agents and brokers and we specialize in medical malpractice insurance.

We can handle all your professional and personal insurance needs. We'll be your claims intermediary.

Don't pay a large premium today and find out tomorrow you had a less expensive alternative. Call Clements & Company now for a market update and a quote. Save your money.

INSURANCE BROKERS WORLDWIDE

CLEMENTS AND COMPANY

Specialists in Medical Malpractice Insurance

(202) 872-0060

Virginia Health Council, Inc.

The recognized source for physician placement in Virginia.

Our non-profit service currently lists hundreds of practice opportunities for physicians. Whether you want mountains, beaches, urban, or rural settings, Virginia has it all. We can help you locate the right practice for you from our hundreds of solo, partnership, group, or hospital-based opportunity listings.

Contact us today.

Virginia Health Council, Inc.
3312 West Cary Street
Richmond, Virginia 23221
(804) 358-9944

The Council's Physician Referral Service operates in cooperation with the Medical Society of Virginia

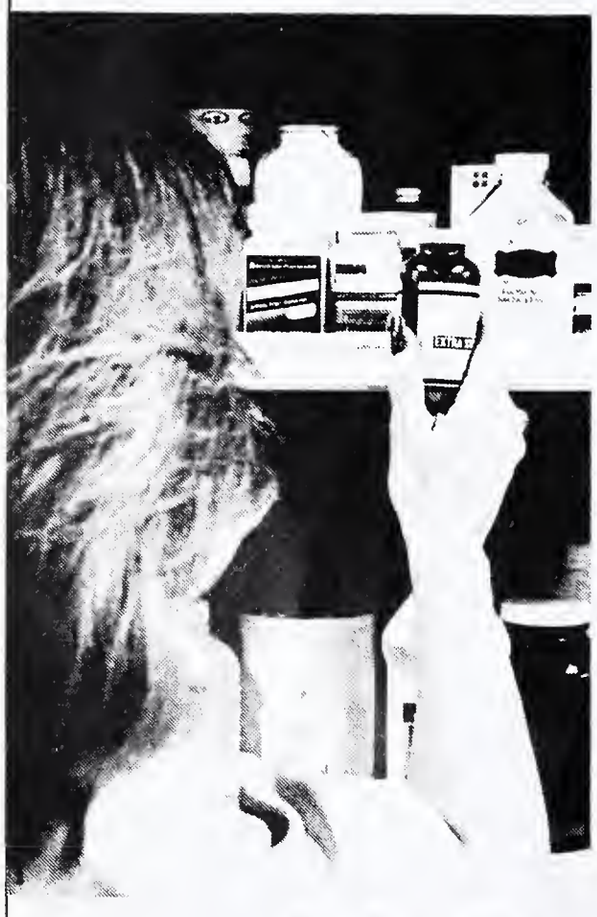
health care delivery, where the bottom line is the bottom line and not patient care. Once again, the business organizations of the HMOs view physicians primarily as employees to do with as they please in order to maintain profit margins.

It is hoped that physicians who work in areas of HMOs take the advice of Dr. Peay. Indeed, the contracts should be carefully reviewed, but more importantly, the principle of medical care being delivered by actuarial decree or HMO decree and not by patient need, must be refuted. Nowhere in the Hippocratic oath is business mentioned, and we physicians need to be prudent in this area as well. Now, if we can only do something about the Medicare bureaucracy and the disparity in rural health care in regard to reimbursement by all third-party "non-payers," health care may be back on its feet taking care of the patients instead of big business.

One final note: Ultimately, when all is said and done and the century moves on, those who run big business will throw up their hands and say, "Medicine is not for us," and the only ones left will be the patients and the physicians—the way it was in the beginning.

Timothy A. Mjos, MD
Rappahannock Orthopaedics, Ltd.
PO Box 609, Kilmarnock VA 22482

1. Peay CL. Point of View: Hoist by an HMO's fine print. Va Med 1989;116:466



HEADACHE

THERE IS AN ALTERNATIVE

Headache is the most common disorder of modern man. It has been estimated that one out of three Americans suffers from severe headaches at one time or another.

The RICHMOND HEADACHE CENTER is a unique facility which specializes in the diagnosis and management of chronic and recurrent headaches.

The RICHMOND HEADACHE CENTER was founded by a group of practicing neurologists and clinical psychologists who recognized the need for a cooperative effort in treating chronic and recurrent headaches.

For more information, write or call .....

YES, please send me more information about RICHMOND HEADACHE CENTER.

NAME

ADDRESS

STATE

ZIP CODE PHONE

MAIL TO: RICHMOND HEADACHE CENTER
909 Hioaks Road, Suite I
Richmond, Virginia 23225

RICHMOND HEADACHE CENTER
909 Hioaks Road, Suite I
Richmond, Virginia 23225
Telephone (804) 320-3750

Lewis-Gale Clinic

Virginia's Largest Multi-Specialty Medical Group Practice

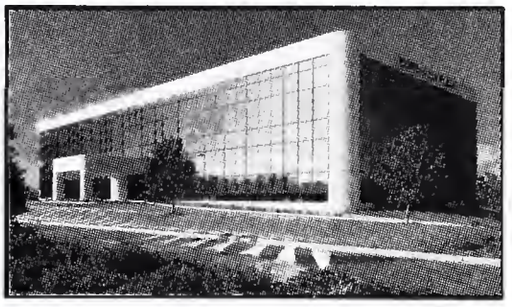
Full Medicare Participation

772-3400

1802 Braeburn Drive, Salem
Adjacent to Lewis-Gale Hospital
772-3400

Business Office
Medicare **772-3760**
All other accounts
(See top of Clinic
monthly statement)

Satellite Family Practice Clinics
BACK CREEK 989-0757
FINCASTLE 992-2110
FORT LEWIS 380-4300
NEW CASTLE 342-7677
WEST SALEM 387-0441



4910 Valley View Blvd., Roanoke
At Valley View Mall
265-1600

ALLERGY & IMMUNOLOGY
Paul F. White, M.D.

ANESTHESIOLOGY
Leigh O. Atkinson, M.D.
George P. Baron, M.D.
Daniel C. Summerlin, Jr., M.D.
Joe F. Clark, M.D.
George S. Coury, M.D.
Gennard T. Lanzara, M.D.

ARTHRITIS & RHEUMATOLOGY / INTERNAL MEDICINE
William M. Blaylock, M.D.
Joseph P. Lemmer, M.D.

CARDIOLOGY
David S. Miller, II, M.D.
Jacob P. Neathawk, Jr., M.D.
J. Phillip Bushkar, M.D.
William B. Rutherford, Jr., M.D.

COUNSELING/PSYCHOLOGY
J. Steven Strosnider, LPC
Samuel B. Rogers, Jr., Ph.D.
Bruce A. Sellers, Psy.D.
John Heil, D.A.

DERMATOLOGY
Gary P. Gross, M.D.
Larry W. Patton, M.D.

EMERGENCY MEDICINE
Benjamin N. Jones, M.D.
John S. Jeremiah, M.D.
John M. Garvin, M.D.
Robert O. McGuffin, M.D.
Thomas Gary Parrish, M.D.
Roger D. Tims, M.D.

EXECUTIVE HEALTH MEDICINE
Lucian Y. Grove, Jr., M.D.

FAMILY PRACTICE
Allen M. Clague, M.D.
Keith C. Edmunds, M.D.
William C. Crow, Jr., M.D.
Samuel N. Smith, M.D.
Howard W. Lebow, M.D.
Wilson H. Coulter, M.D.
John F. Daugherty, M.D.
Clarke B. Andrews, M.D.
Marc G. Nevin, M.D.
Ella M. Dickinson, M.D.
Kevin C. Kelleher, M.D.
David A. Keilman, M.D.
Gregory L. Still, M.D.
James W. Robinson, M.D.
Charles E. Lamb, M.D.
Clement B. Binnings, Jr., M.D.
William C. Greer, M.D.
Victor H. Bell, M.D.

FERTILITY & REPRODUCTIVE HEALTH
James Freeman Holman, M.D.

GASTROENTEROLOGY & ENDOSCOPY/ INTERNAL MEDICINE
George H. Wall, M.D.
Joseph L. Nelson, III, M.D.
M. Jonathan Bern, M.D.
Douglas W. Kirtley, M.D.

HEMATOLOGY & ONCOLOGY/ INTERNAL MEDICINE
Paul D. Richards, M.D.
William A. Fintel, M.D.

INFECTIOUS DISEASE/ INTERNAL MEDICINE
Douglas D. Blevins, M.D.

INTERNAL MEDICINE
Michael J. Moore, M.D.
E. Blackford Noland, Jr., M.D.
Myron S. Levey, M.D.
Daniel M. Camden, M.D.
Lucian Y. Grove, Jr., M.D.

NEUROLOGY/ NEURO-OPHTHALMOLOGY
Edward A. Waybright, M.D.
Timothy L. Hormel, M.D.
Gary J. Harpold, M.D.

NEUROSURGERY
Charles H. Anderson, Jr., M.D.

OBSTETRICS & GYNECOLOGY
Carl B. Harms, M.D.
James A. Kelly, M.D.
George W. Maxymiv, M.D.
Debra H. Clapp, M.D.

OCCUPATIONAL MEDICINE
E. Wilson Watts, Jr., M.D.
Darrell F. Powledge, M.D.

OPHTHALMOLOGY
J. Stanwood Till, M.D.
Donna L. Maxfield, M.D.

ORTHOPAEDIC SURGERY
Richard H. Fisher, M.D.
Alonzo H. Myers, Jr., M.D.
S. Curtiss Mull, M.D.
Bertram Spetzler, M.D.
John P. Clarke, M.D.
Brian A. Torre, M.D.
James W. McLeod, M.D.

OTOLARYNGOLOGY
J. Bruce Hagadorn, M.D.
Tu A. Tran, M.D.

PATHOLOGY
Anthony V. Torre, M.D.

PEDIATRICS
F. Joseph Duckwall, M.D.
William J. Kagey, M.D.
Lee Anne Steffe, M.D.
Luthur A. Beazley, III, M.D.
Dawn Elizabeth Forbes, M.D.

PLASTIC RECONSTRUCTIVE & HAND SURGERY
Warren L. Moorman, M.D.
Robert F. Roth, M.D.
Carol A. Reichel, M.D.

PULMONARY DISEASES/ INTERNAL MEDICINE
James A. Witten, Jr., M.D.
Nelson B. Greene, M.D.

RADIOLOGY & NUCLEAR MEDICINE
Clyde F. Lloyd, M.D.
William A. Cassada, Jr., M.D.
J. William Barnard, M.D.
John M. Mathis, M.D.
Mary Ella Zelenik, M.D.
Placido H. DeGuzman, M.D.
Bruce C. Banning, Jr., M.D.
Nathaniel W. Cuthbert, M.D.

GENERAL THORACIC & VASCULAR SURGERY
William L. Sibley, III, M.D.
George R. Shumate, M.D.
A. Reif Kessler, M.D.

UROLOGY
T.S.R. Ward, M.D.
Jeffrey S. Jones, M.D.

Accredited by the
Accreditation Association
for Ambulatory Health Care

142nd Annual Meeting

Summarized in these pages are actions taken by the House of Delegates during its second session on November 11 during The Medical Society of Virginia's annual meeting in Richmond. Dr. J. Thomas Hulvey was the presiding officer. Conducting the deliberations of the House were Dr. George E. Broman, Speaker, and Dr. Lawrence K. Monahan, Vice Speaker.

REFERENCE COMMITTEE ONE: Education and Interprofessional Relations

J. Latane Ware, MD, Chairman
Louis D. Parham, Jr., MD, James P. Baker, MD, Henry D. Patterson, MD, Jack C. Turner, MD, John T. Hearn, MD, Daniel N. Mohler, Jr., MD, Joseph V. Puglise, MD, Thomas M. Fulcher, MD, and Samir Keblawi (Student)

Address of the President

Reference Committee One commended Dr. J. Thomas Hulvey for his "perceptive and outstanding" presidential address, Chairman Ware told the delegates, and recommended that it be distributed to the entire membership. (See page 32.)

The Committee also recommended that **Dr. Hulvey be elected an honorary active member of the Medical Society of Virginia,** and the House did so forthwith.

Electronic Billing

Agreeing with the Reference Committee's endorsement, the House adopted the following six recommendations from the Report of the Electronic Billing Committee:

1) That the Society not attempt to initiate an electronic billing service but encourage vendors to enter the market;

2) That dialogue with Blue Cross/Blue Shield regarding the electronic billing issue be encouraged;

3) That a system be developed to keep track of the time required to process paper claims;

4) That the Society urge Blue Cross/Blue Shield to use the information it receives from Medicare on the explanation of benefits to pay claims;

5) That the Society alert hospitals to the fact that information from Blue Cross/Blue Shield data may be sold to them and that hospital staffs should make every attempt to ensure that they are notified when such a transaction takes place;

6) That the Society continue to monitor the activities of Blue Cross/Blue Shield with respect to electronic billing.

Access to Care

Four resolutions from the Virginia Academy of Family Physicians had been referred to Reference Committee One for study.

The first called for the Medical Society of Virginia to seek a pilot

Taylor Dabney photographed the annual meeting.

Executive Editor Ann Gray wrote the report of the delegates' actions.

Shown above immediately after their election during the House of Delegates' second session are the Medical Society of Virginia's officers for 1989-1990. Seated in front at left is the President, Dr. William H. Barney, Lynchburg. Seated at right is the President Elect, Dr. John A. Owen, Jr., Charlottesville. Behind Dr. Owen are Dr. Leon I. Block, Falls Church, First Vice President (left), and Dr. William W. Regan, Richmond, Second Vice President. Behind Dr. Barney are Dr. George E. Broman, Culpeper, Speaker of the House (left), and Dr. Lawrence K. Monahan, Roanoke, Vice Speaker, both of whom were reelected. The newly elected Third Vice President, Dr. William H. Sipe, Newport News, was not present for the photograph.

The delegates also elected two new councilors, Dr. Louis D. Parham, Hampton (1st District), and Dr. James A. Shield, Jr., Richmond (3rd District), and two new vice councilors, Dr. Norman R. Edwards, Newport News (1st), and Dr. Lawrence E. Blanchard, Richmond (3rd). The other councilors and vice councilors were reelected.

For a complete listing of the new officers, see page 28.

On the floor of the House: At left, Dr. William J. McAveney, Springfield. Below, from left, Dr. Richard N. Baylor, Kilmarnock, Dr. J. Colin Forrester, Callao, and Dr. Timothy J. Mjos, Kilmarnock.

program to offset the increased liability premiums levied on family physicians and obstetricians who provide obstetrical services to women in underserved areas. The second asked the Society to pursue implementation of a comprehensive plan to ensure health care access for the uninsured.

The Committee heard testimony, Dr. Ware related, that several initiatives regarding access-to-care issues were being conducted by both the Society and the State of Virginia in preparation for the 1990 session of the General Assembly. Accordingly, the Committee believed both of these resolutions should be referred to the MSV State Legislative Committee. The House so referred them.

The third resolution from the Academy asked the Society to refer to one of its committees the task of considering the implications of the universal health care program being promoted by an organization of physicians. Again the Committee recommended referral to the Society's State Legislative Committee and again the House concurred.

Managed Care Plans

The fourth resolution from the Virginia Academy of Family Physicians related to utilization of services; it brought half a dozen delegates to the microphones for

In the column at right, at top, Dr. Paul Kaufman, Arlington; center, Dr. Douglas H. Chessen, Newport News, with Dr. Harold W. Felton, Deltaville, behind him; and bottom, Dr. Randolph J. Gould, Norfolk.

discussion and wound up the object of a close standing vote. Reference Committee One had added to its language, as shown below, and it was these amendments that were contested:

RESOLVED, that the Medical Society of Virginia support the concept of appropriate utilization, i.e., that any medical professional reimbursement system that rewards underutilization or overutilization with greater profits is contrary to the best interests of patients and detrimental to the professional ethical behavior of physicians.

One delegate disagreed with the insertion of "or overutilization." Another favored both changes, especially the words "appropriate utilization." Other delegates rose to offer shades of these two opinions. The voice vote on the resolution as amended was too close to call. Vice Speaker Monahan ordered a standing vote and the tellers counted. The resolution as amended was adopted 86–67.

ORGAN DONORS

Health care coverage for organ donors was the concern of a resolution from the Virginia Chapter of the American College of Surgeons. It was the decision of the Reference Committee that "the State Legislative Committee is in the best position to investigate possible funding mechanisms for donor trauma patient's medical care," and the Committee recommended that the resolution be so referred. The delegates adopted the Committee's recommendation.

PRIVATE PRACTICE PARAMETERS

The Reference Committee had added two words, "and therapeutic," to a resolution from Dr. C. Barrie Cook to make it more comprehensive, Dr. Ware explained. Thus amended, it read as follows:

RESOLVED, that the Medical Society of Virginia seek introduction at the next meeting of the AMA's House of Delegates of a resolution which would require the officers, member groups and staff of the AMA to involve appropriate members of the federation of organized medicine in the process of developing and approving diagnostic and therapeutic practice parameters affecting more than one specialty.

The amended version was adopted without discussion.

CONSENT CALENDAR

Reference Committee One recommended the adoption of these three items and the delegates did so.

1) Report of the Maternal Health Committee, including this recommendation: **That all health providers, especially emergency room personnel and practicing physicians, be ever aware of ectopic pregnancy as a cause of death among young women almost every year in Virginia.**

2) A resolution from the Virginia Society of Internal Medicine asking the Medical Society of Virginia to **"urge the Medicare carrier in Virginia to maintain accurate and uptodate lists of physicians who participate in the Medicare program for use by Medicare beneficiaries interested in selecting participating physicians for their medical care."**

3) The Lynchburg Academy of Medicine's resolution requesting the Medical Society of Virginia to **"oppose the practice of 'hotboxing' or any similar process of dangerous rapid weight reduction and to help inform all state, public, and private schools, as well as recreation departments, of the dangers inherent in this practice and of the opposition of the Medical Society of Virginia to such practices."**

We've been defending doctors since these were the state of the art.

Turn of the century trephine for cranial surgery and tonsillotome for removing tonsils.

These instruments were the best available at the turn of the century. So was our professional liability coverage for doctors. In fact, we pioneered the concept of professional protection in 1899 and have been providing this important service exclusively to doctors ever since.

You can be sure we'll always offer the most complete professional liability coverage you can carry. Plus the personal attention and claims prevention assistance you deserve.

For more information about Medical Protective coverage, contact your Medical Protective Company general agent.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Ted J. Pandak, David R. Fuller
Suite 205, 7275 Glen Forest Drive Richmond, Virginia 23226, (804) 285-4131

REFERENCE COMMITTEE TWO: Legislation and Regulation

Russell D. Evett, MD, Chairman
Robert T. Davis, MD, Lawrence E. Blanchard III, MD,
George J. Carroll, MD, Henry S. Campell, MD,
William E. Painter, MD, Joel R. Poole, MD,
Donald D. Haut, MD, Joseph H. Early, Jr., MD,
Richard E. Linde, MD, and Mike Williams (Student)

Tobacco Use

Reference Committee Two's report led off with a brace of resolutions relating to tobacco use. Chairman Russell Evett asked the delegates to turn their attention first to a lengthy resolution introduced by the Arlington and Fairfax Counties Medical Societies; it incorporated five Resolved clauses, four of which the Reference Committee recommended adopting forthwith, and the delegates did so, as follows:

1) That the Medical Society of Virginia endorse the AMA goal of a smoke-free society by the year 2000;

3) That the Medical Society of Virginia specifically support legislative efforts to restrict or eliminate tobacco smoke in public indoor spaces in order to protect Virginians from the hazards of passive smoke inhalation;

4) That the Medical Society of Virginia oppose any legislation which constrains local governing bodies from adopting more restrictive ordinances relative to smoking to protect their citizens;

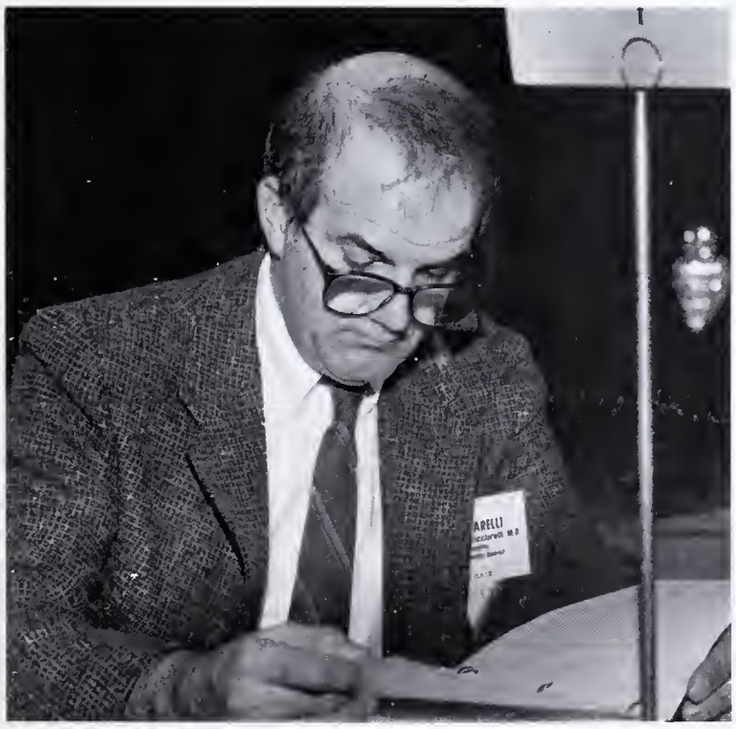
5) That the Medical Society of Virginia oppose any legislation designed to force repeal of any ordinances already in place to protect the public from secondhand smoke.

The original Clause 2 had read, "That the Medical Society of Virginia support and seek passage of legislation in the General Assembly to restrict tobacco use in Virginia." The Reference Committee had developed this substitute clause, Chairman Evett reported, and recommended its adoption: "That the Medical Society of Virginia support public and private programs to discourage the use of tobacco products in Virginia."

At once there were delegates at the mikes, asking for recognition. Support for the extant programs is not what's needed, they said; what's needed is legislation. But there was agreement that the words "and seek" in the original resolution might well be omitted, since the Society should not be asked to introduce legislation. After considerable discussion, the original Clause 2, minus only the words "and seek," was adopted by the delegates as follows:

Resolved, that the Medical Society of Virginia support passage of legislation in the General Assembly to restrict tobacco use in Virginia.

Dr. Evett continued with other items on tobacco use. It was the Committee's consensus, he reported, that the Cancer Committee's recommendation to support appropriate



Dr. Giacomo A. Ricciarelli, Hampton

Dr. James E. Nevin III, Danville, and Dr. H. S. Campell, Martinsville

clean air legislation in the 1990 General Assembly had been adequately covered by the resolution just adopted, as had a resolution from the Virginia Chapter, American Academy of Pediatrics, and the Virginia Pediatric Society asking the Society to seek a Virginia Clean Indoor Air Act. Accordingly, Reference Committee Two did not recommend action on those measures.

But the Committee had decided that a resolution on tobacco products from the Hampton Medical Society merited adoption, the chairman said, although it needed some amending, as follows:

RESOLVED, that the Medical Society of Virginia ~~seek legislation which would prohibit~~ oppose the sale of tobacco products to children under the age of 18, ~~prevent~~ oppose access by children under the age of 18 to vending machines containing tobacco products, and ~~which would prohibit~~ oppose the use of tobacco products by children under the age of 18 in public places, including schools and school grounds.

Dr. Evett explained that the Committee fully supported prevention of tobacco addiction in children and opposition to the sale of tobacco products to minors, but it was felt that the laws already in place made it difficult to draft additional legislation.

The resolution as amended was adopted.

RURAL HEALTH

The Report of the Rural Health Committee had been referred for consideration to Reference Committee Two. It carried the recommendation that the Medical Society of Virginia adopt 14 statements "as a portion of its position and policy on rural health matters in Virginia and the nation."

The Reference Committee heartily endorsed the efforts of the Rural Health Committee to provide specific methods of addressing the problems of rural physicians, Dr. Evett

MEDICAL SOCIETY OF VIRGINIA
BUDGET 1988-1989

Salaries	$495,000
Stationery and Supplies	19,000
Office Equipment: Repairs and Replacement	10,000
Building Expense	5,000
Building Maintenance/Repairs/Improvements	45,000
Telephone	14,000
Postage	20,000
Convention Expense	40,000
Council and Committee Expense	20,000
Delegates to American Medical Association	55,000
Staff Travel—AMA	6,000
President's Expense	14,000
Presidential Expense Allowance	15,000
President Elect Expense Allowance	3,000
Staff Travel Expense	8,000
Preparation and Distribution of VIRGINIA MEDICAL	105,000
Editor, VIRGINIA MEDICAL	2,400
Legal Expense	110,000
Legislative Program	35,000
Walter Reed Commission	1,000
MSV Auxiliary	7,000
Membership Dues, Affiliated Agencies	1,000
Special Appropriations	
AMA/ERA	1,000
Scholarships	
Medical College of Virginia	1,000
University of Virginia	1,000
Eastern Virginia Medical School	1,000
Rural Health	1,000
Student Medical Societies	
Medical College of Virginia	4,000
University of Virginia	4,000
Eastern Virginia Medical School	4,000
Virginia Health Council	1,000
Hospital Resident Section	1,500
Other Special Appropriations	10,250
Indigent Care Survey	5,000
Injured Infants Act Study	6,487
Insurance Premiums	17,000
Marketing	5,000
Professional Liability and Tort Reform	80,000
Campaign Expenses	15,000
Newsletter	7,000
Employee Benefits	
Retirement Fund	122,500
Blue Cross/Blue Shield, Life, and Disability	25,000
Payroll Taxes	35,000
Continuing Medical Education	18,000
Consulting Services	
Legislative and Public Relations	65,000
Insurance Actuary	18,000
Physicians' Health and Effectiveness Program	24,776
Part-Time Medical Director	26,250
Miscellaneous	5,000
Computer Operation and Maintenance	6,000
Audit	15,000
TOTAL	$1,556,163

Rank has its privileges.

When you want to call one of our pharmacists, you shouldn't have to go through the phone at the checkout counter or the photo department.

We make sure you get through directly with our special unlisted phone that's reserved for doctors–only–and answered by pharmacists...only. That way, your valuable time isn't wasted. And your patients get the exact prescriptions they need...when they need them.

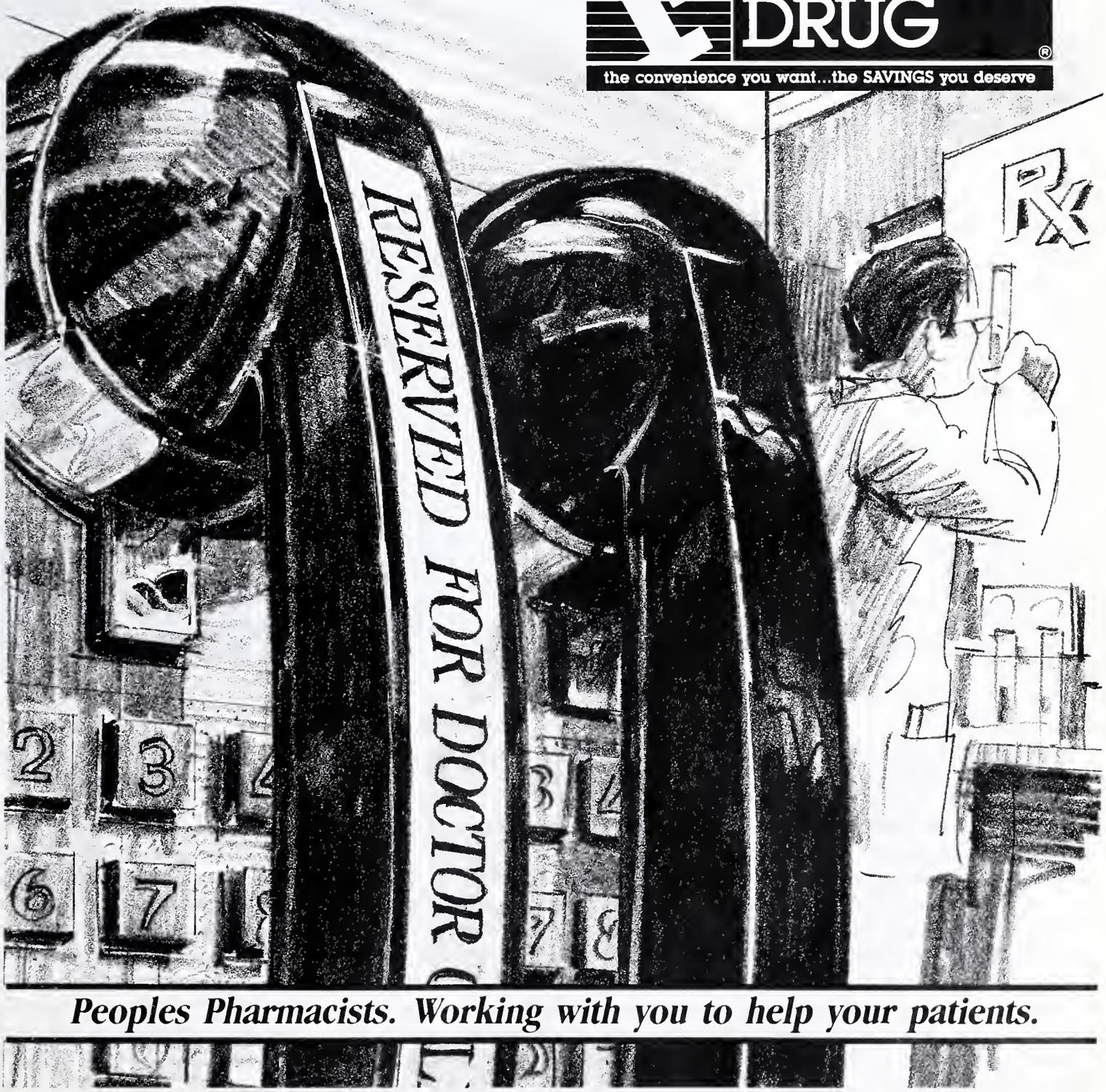
It's just another example of how–for over 80 years–Peoples Drug has served its customers with unmatched care and professionalism.

Today, all our services reflect our continuing commitment to meeting the changing needs of *your* patients...who become *our* customers.

And–as our 'hot line' illustrates–we're committed to meeting your needs, as well.

PEOPLES DRUG®

the convenience you want...the SAVINGS you deserve



Peoples Pharmacists. Working with you to help your patients.

WINNERS

As the only physician in Victoria, Virginia, **Dr. Lewis W. Bridgforth** has been on call day and night for 23 years, answering as doctor, adviser, and friend. A thoroughly modest man, he has always clung to the notion that most of what he has done for the people of Victoria was known only to those he has helped. In 1989, that notion went out the window.

First the Victoria Chamber of Commerce surprised him with its Citizen of the Year Award, complete with ceremonial dinner, engraved plaque, prolonged applause, popping flash bulbs—the whole public recognition bit. So acute was Dr. Bridgforth's consternation that he "could hardly make it to his feet," one witness said.

As it turned out, that was a practice run for the Victoria physician's second surprise of the year. This time the setting was the Medical Society of Virginia's annual meeting banquet, with Dr. J. Thomas Hulvey, outgoing MSV President, presiding.

"For all the technological advances that make us better doctors, medicine is still a very human profession," Dr. Hulvey began, "and the spirit of the country doctor lives on. We are more than just mechanics for the body; we are here to comfort, to listen, and to advise. The recipient of this year's A. H. Robins Community Service Award embodies these qualities." Dr. Hulvey launched into some specifics.

The winner's contributions to the children of his community include giving free physicals to members of the local high school's athletic teams, as well as to local Little League and Midget Football teams, "a huge commitment of time," Dr. Hulvey observed, "yet he has been doing it for over 20 years. He holds clinics for children on his free afternoons, and turns his farm over to the Boy Scouts for wilderness weekends and jamborees."

Winner Bridgforth and wife Betty

He goes far beyond "just treating skinned knees. He provides a positive role model at a time when kids need honest adults to look up to," Dr. Hulvey continued, and he cited this quote from a member of the staff at the local high school: "He has always been available to the needs of our athletes, always willing to come out late at night, when we return from a game, to examine the kids. In the eyes of the youth of the county, he is the hero of the community."

The award winner is "still on cal 24 hours a day," Dr. Hulvey related "and his extended office hours ar for more than just medical help; pa tients come to him for family, lega and financial advice. Not long ago family called at 11:30 at night in th midst of a family crisis. The docto invited them into his home an helped them work through the prob lem until 2:00 in the morning."

Finally, although the winner ha never held local office, "he has bee

ound whenever the community eeded leadership," Dr. Hulvey re- ted. "He was instrumental in the evelopment of a local county bank id has served as an officer and irector."

"Now," concluded Dr. Hulvey, it is my honor to say thank you on behalf of the Medical Society of Vir- nia and bestow this year's Commu- ity Service Award on a man born ere in Virginia, educated at Hamp- n-Sydney, graduated from the Medical College of Virginia, and an utstanding citizen of Victoria, Vir- inia—Dr. Lewis W. Bridgforth!"

This time Dr. Bridgforth got to his et without noticeable difficulty, aded swiftly through his applaud- g peers to the dais, ducked his ead in thanks to Dr. Hulvey, and urned to meet the flash bulbs. learly, he was getting the hang of .

A native of Crewe, Virginia, Dr. ridgforth established his medical ractice in Victoria, a rural commu- ity (pop. 2,004) much like the one in hich he grew up, in 1966. He was resident in 1985 of the Southside Medical Society and is the 26th re- ipient of the Community Service ward.

Awarded the Challenge Cup at the nnual MSV golf tourney on the Country Club of Virginia's course as **Dr. Gerald C. Burnett**, South Boston, who carded the low net of 2. One shot off the pace for second lace was **Dr. Richard N. Baylor**, Kilmarnock, with a low net of 73. **Dr. John T. Hearn** of Penn Laird, who posted a low gross of 74, won irst prize in that category. Other rizes went to **Dr. C. B. Courtney, r.**, Newport News, who had the ongest drive on #8, **Dr. Norman R. Edwards**, also Newport News, who as closest to the pin on #7 green, nd **Dr. Victor N. Guerrero**, Manas- sas, who was closest to the pin at the 16th hole.

The **Robert P. Trices** of Richmond swept the tennis tourney, with Dr. Trice winning the men's singles, then joining his wife, Edmonia, to take the mixed doubles title.

The commercial exhibits hall was loaded, with handouts and prizes galore from 73 exhibitors.

At the John P. Pearl & Associates booth, **Dr. Henry A. Yancey**, Richmond, won the men's watch, and **Dr. Clyde H. Dougherty**, Hopewell, won the ladies' watch. The 7½-pound cookbook, *Dining at the Homestead*, raffled off by Saint Albans Psychiatric Hospital was won by **Dr. John A. Owen, Jr.**, Charlottesville, who also won an election at the meeting, as see page 11.

The briefcase offered by Sentient Systems was won by **Dr. James L. Van Dyke**, Galax. At the Miles Pharmaceuticals booth, **Dr. Emmett C. Mathews**, Richmond, won a Sony Walkman; the Old Timey Radio raffled by the Haycraft Insurance Agency was won by **Dr. Gerald Weitzman**, Portsmouth; and at the First Insurance Resources booth, a portable TV was won by **Dr. Ganesh Nirmul**, Suffolk.

The prize at the E. R. Squibb booth was a big basket of Virginia products; it was won by **Dr. Norman R. Tingle, Jr.**, Lively. Offered as prizes at the booth of W. B. Saunders were two medical books; they went to **Dr. Jack C. Turner**, Danville, and **Dr. Albert L. Roper**, Norfolk. Two dozen physicians won bottles of wine at the Home IV Care & Nutritional Services booth.

In turn, the Medical Society of Virginia conducted a drawing for the reps in the exhibit hall. Lisa Moreland of the Upjohn Company held the winning ticket and took home the prize, a Virginia ham.

reported, but it felt that such a broad range of recommendations could not be dealt with effectively in a reference committee setting. Accordingly, its members felt the 14 recommendations should be referred to Council for assignment to appropriate committees.

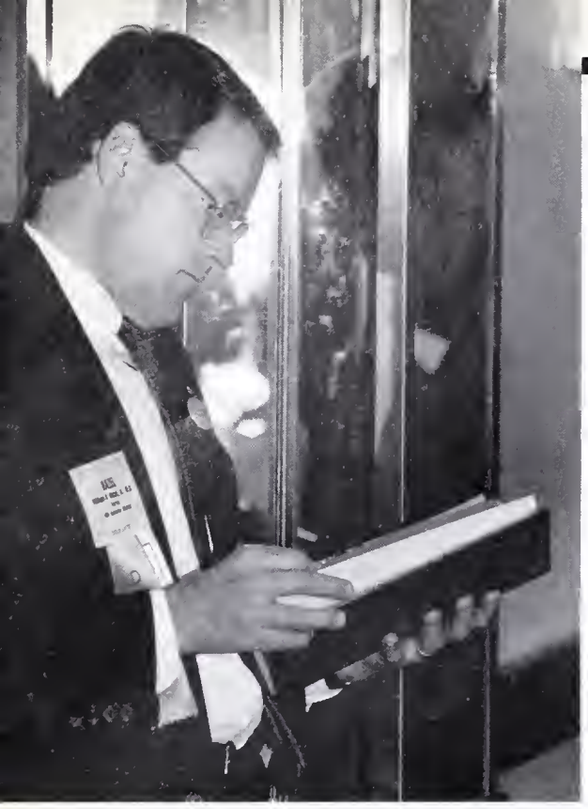
The House agreed and referred as recommended.

Also referred to Council was a resolution relating to a position paper from the Virginia Academy of Family Physicians and "addressing five major barriers to increasing the number of well-trained primary care physicians in Virginia's rural areas." The Resolved clause asked the Medical Society of Virginia to adopt the position paper and work toward reducing the cited barriers. It was noted by the Reference committee that the Society is in the process of analyzing data from a recent survey of primary care physicians and obstetricians throughout the state regarding access to care.

Firearm Legislation

From the Richmond Academy of Medicine came this resolution supporting firearm legislation: **Resolved, that the Medical Society of Virginia wishes to be on record as favoring methods which control this outbreak of misuse and violent use of firearms, particularly assault and military weaponry.**

The preamble to the resolution cited the easy availability and increasing use in Virginia of lethal weapons and gave the estimated cost of care for gunshot wound victims at $10,000–$15,000 per incidence. Dr. Warren W. Koontz, Academy president, spoke in support of the resolution, citing a study of 535 patients with renal trauma admitted to the Medical College of Virginia (Va Med December 1989). The study's data indicated a decrease in the rate of total nephrectomy except in patients with gunshot wounds; in these cases, a persistently high rate prevailed, re-



At Reference Committee Two's hearing, Dr. William A. Hazel, Jr., Herndon, at top, and at center, from left, Dr. George A. Hurt, Lynchburg, Dr. Richardson Grinnan, Richmond, and Dr. Donald E. Sly, Norfolk. In the hallway outside the hearing, bottom, are Dr. Michael W. Russell, Culpeper, and Dr. Harry C. Kuykendall, Alexandria

flecting, the study suggested, the proliferation of increasingly lethal weaponry.

The Reference Committee was in favor of adopting the resolution, its Chairman reported, but recommended deleting mention of an outbreak. A spirited discussion ensued in the House on the proposed "outbreak" deletion and also on the semantics of "assault and military weaponry," but the delegates wound up by adopting the resolution as written.

A resolution on the protection of children from firearms introduced by the Virginia Chapter, American Academy of Pediatrics, and the Virginia Pediatric Society offered two Resolved clauses. One sought "legislation to restrict the availability of firearms, particularly to minors" and the other asked for legislation making the owner of a firearm liable "if the firearm is accessible to a person under 21 and is used in a crime by or involved in unintentional injury of a minor."

As drafted, the resolution was deemed by the Reference Committee to be overbroad, and adoption was not recommended. The House so voted.

Injured Infants Act

Introduced by the Virginia Academy of Family Physicians was a resolution asking the delegates to adopt another position paper developed by the Academy regarding the Virginia Injured Infants Act.

"Reference Committee Two supports the position paper developed on the subject by the Medical Society of Virginia's State Legislative and Professional Liability Committees," Dr. Evett told the delegates, "and does not feel it would be appropriate to adopt an alternative paper in its place." The Committee therefore recommends, he continued, that the resolution be referred to the Professional Liability Committee. The Chairman noted that testimony at the Committee's hearing indicated the two organizations' position papers were similar in content. The House voted to refer.

Drunk Driving

A resolution from the Norfolk Academy of Medicine had to do with

Top right, Dr. Charles J. Gueriera, Manassas, in the Richmond Marriott's lower lobby. Conversing in the same corridor are, at center, Dr. Randall H. Suslick, Chase City, and Dr. Ronald K. Davis, Richmond; and at bottom, Dr. Lockhart B. McGuire, Charlottesville, and Dr. Eugene F. Poutasse, Richmond.

revoking the driver's licenses of Virginians who were found to have high blood alcohol levels or who refused blood alcohol tests.

The Reference Committee endorsed the resolution's intent but amended it slightly so that it did not suggest that the Society introduce legislation. As amended by the Committee and adopted by the delegates, it read:

Resolved, that the Medical Society of Virginia support legislation which would enact administrative driver's license revocation for drivers whose blood alcohol content exceeds the legal limit or who refuse a blood alcohol determination.

Private Review

The Norfolk Academy of Medicine had introduced a resolution relating to regulation of private review; it was prompted, stated the preamble, by the increasing frequency with which insurance companies include contractual requirement for precertification and length of inpatient stay. These requirements, the resolution stated, "are becoming more and more complicated, difficult and time-consuming for physicians and their staffs to manage."

The resolution asked for relief through legislation or regulation requiring insurance companies to 1) retain sufficient personnel to perform such review; 2) make this personnel "immediately accessible" to their subscribers' physicians, rather than placing the task of obtaining such approval on the physicians; and 3) provide notarized releases in advance authorizing physicians to disclose information about their subscriber-patients over the telephone, "in order to protect the privacy of the patient and the integrity of the physician."

A worthy concept, Reference Committee Two agreed, but it felt the State Legislative Committee best qualified to determine what type and level of regulation would be appropriate. The House concurred and referred the resolution accordingly.

Peer Review

Easement of peer review requirements relating to emergency surgery was the goal of a resolution from the

The photographs on these pages were taken in the Exhibit Hall. Above, Dr. Frederick W. Parker III, Manassas, with Mike Wysocki of Searle Laboratories. Below, Dr. Clarke Russ, Virginia Beach looks over the titles at the W. B. Saunders booth while rep Ginny Mackie stands by.

Medical Society of Virginia's Council. Reference Committee Two recommended the change of one word before adopting. The amended resolution:

RESOLVED, that the Medical Society of Virginia submit a resolution to the American Medical Association House of Delegates which would ~~require~~ request the AMA to encourage the Health Care Financing Association to amend the PRO Third Scope of Work to allow at least two working days to obtain an authorization number for emergency surgery when such surgery requires pre-procedure review.

The House adopted the resolution as amended.

PHYSICIAN REIMBURSEMENT

Once again resolutions from the Virginia Academy of Family Physicians appeared in Reference Committee Two's report. One measure (Resolution O) had to do with inequities in Medicare reimbursement between primary care and procedure specialists, the other (Resolution T) asked for the Medical Society of Virginia to conduct a study of the Harvard Resource-Based Relative Value Scale (RBRVS).

After hearing a lot of testimony about these two resolutions, reported the Chairman, the Committee had decided that neither resolution should be adopted, due to the fact that both subjects are being considered at the state level by the MSV Committee on Federal Legislation and at the national level by the AMA.

The discussion was lively pro and con. Out of it came the adoption of this significantly amended version of Resolution O:

RESOLVED, that the Medical Society of Virginia direct its State and Federal Legislative Committees to support the AMA's position on the Harvard RVRBS.

That cancelled the need for Resolution T and it was not adopted.

Obstetrical Care

After spirited discussion, Reference Committee Two's recommended amendments to a resolution on obstetrical care were rejected by the delegates and the original reinstated for passage. As framed by the Virginia Academy of Family Physicians and adopted by the House, it read:

Resolved, that the Medical Society of Virginia urge the state legislature to provide assistance to physicians presently providing obstetrical care without reimbursement or with limited reimbursement. The Committee's amendments spoke of "incentives," and the House was in no mood for incentives, it wanted assistance for these doctors.

Health Insurance

There was quite a little debate, too, on a resolution on child health insurance reform introduced by the Virginia Chapter, American Academy of Pediatrics, and the Virginia Pediatric Society. It proposed mandating a package of preventive health care services for children in every health insurance policy written in Virginia.

Reference Committee Two did not recommend adoption of the measure, Chairman Evett explained, because of testimony that "the existing moratorium on mandated benefits in Virginia in response to the substantial cost increases that have resulted from a steady rise in the number of mandated benefits, and these increased insurance costs have led to a surge in the number of uninsureds." Therefore, although the Reference Committee recognized the desirability of adequate insurance coverage for the care of children, it had concluded that it was not practical to recommend any additional mandated benefits at this time.

After some discussion, the delegates first amended the resolution so that the insurers would be required to offer, rather than include, the desired coverage and then voted to

Above, Jim Thomson of Merck, Sharpe & Dohme listens to Dr. Sigsby W. Gayle, Richmond, Exhibits Chairman.
Below, Dr. Kang H. Rah, Richmond, signs in for a prize at the John Pearl & Associates booth as Gary Pearl and Mike Huennekins look on.

While Medical Society of Virginia members were conducting their annual meeting, the MSV Auxiliary was holding its midyear board meeting, in which the two women above had leading roles. At right is Mrs. Carroll T. (Vivian) Petty, Richmond, MSVA President 1989-90. With her is the President Elect Mrs. Victor N. (Heidi) Guerrero, Manassas.

refer the matter to the State Legislative Committee.

Another resolution from the two groups of pediatricians dealt with "limited access to comprehensive, continuous primary health care and services by virtue of the inadequacy of Medicaid reimbursement for such services" and asked the Medical Society of Virginia to seek from the General Assembly additional budget appropriations that would raise reimbursement to usual, customary and reasonable levels. On the recommendation of the Reference Committee, the House referred this resolution also to the State Legislative Committee.

From the Virginia Chapter of the American College of Surgeons came a resolution asking for a legislated funding mechanism to pay for medical care given uninsured persons injured in motor vehicle accidents.

Again the Reference Committee recommended referral to the Society's State Legislative Committee, but this time sent with it the authority to take action. The House referred as recommended.

Drug Dispensing

Next on Reference Committee Two's agenda was a resolution from the Norfolk Academy of Medicine calling for regulatory legislation of bulk sales of scheduled drugs. The Committee favored adoption, the Chairman reported, but recommended changing one word, as follows:

Resolved, that the Medical Society of Virginia ~~seek~~ <u>support</u> legislation to authorize the Virginia State Boards of Medicine and Pharmacy to regulate bulk sales of scheduled drugs.

The House adopted the resolution as amended.

Denial of Claims

These two Resolved clauses culminated the Roanoke Academy of Medicine's submitted resolution on denial of claims:

Resolved, that the Medical Society of Virginia request the State Commissioner of Insurance to instruct health insurers, when communicating to their clients a lack of coverage, to strenuously avoid the implication that the physician's charges were excessive, but instead plainly and simply state that the policy does not cover all the charges generated.

Resolved, that the Medical Society of Virginia recommend to the Commissioner that the health insurers be instructed to strenuously avoid implying that the charges generated in the claim may not have been medically necessary.

It was Reference Committee Two's observation that "it is not practical to look to the Insurance Commissioner to force changes in these behavior patterns," and the Committee recommended that both clauses be amended to delete the Commissioner from the equation and instead "urge the insurers" to refrain from these derogatory comments.

Numerous delegates rose to speak to the measure. All wanted the original proposal, some wanted slight changes here or there. The consensus finally reached was that the original resolution be referred to Council with a request for action.

Generic Drugs

The House also wanted action on a resolution from the Virginia Academy of Family Physicians asking the Medical Society of Virginia to adopt a group of recommendations on generic drugs relating particularly to therapeutic substitution and, on Reference Committee Two's recommendation, referred it for that action to the Society's Therapeutics and Devices Committee.

The Dual Diagnosis Treatment Program of Sheppard Pratt

Patients with psychiatric illness and drug or alcohol problems present complex diagnostic and treatment challenges.

Sheppard Pratt's inpatient units are designed and staffed specifically for the treatment of these complicated patients.

We provide:

- ☐ Comprehensive psychiatric and chemical dependence evaluation;
- ☐ Specialized programs for patients with affective disorders, anxiety disorders, schizophrenia and learning disorders;
- ☐ Psychopharmacological evaluation and treatment;
- ☐ Specialized programming for the gerontological patient who is chemically dependent;
- ☐ Addiction education for the psychiatric patient who is resistant to treatment for chemical dependence; and
- ☐ On site Double Trouble, AA and NA meetings.

Founded in 1853, Sheppard Pratt is a 322-bed private, not-for-profit psychiatric hospital that provides comprehensive diagnostic and treatment services for short, intermediate or long term patients as well as outpatient and partial hospitalization care.

For more information about Sheppard Pratt's approach to the dually diagnosed patient, or to make a referral, contact the Adult Admissions Office at:

(301) 938-3800
6501 North Charles Street
Baltimore, Maryland 21285-5815

Sheppard Pratt
A not-for-profit health system

STOP PAYING FOR MALPRACTICE INSURANCE AND RETIRE EARLY!

IF YOU'VE DREAMED OF **EARLY RETIREMENT**
BUT HAVE "**LOCKED UP**"
MOST OF YOUR ASSETS IN *RETIREMENT PLANS...

WE'VE GOT NEWS FOR YOU

- Through certain provisions in the IRS Code, there is a way to access income from your retirement plans *prior to age 59½—WITH NO IRS PENALTIES*
- There is available at *no charge,* a *no-risk* fixed income program that will calculate the permitted distributions for current income and *protect you against any IRS penalty*
- If you are considering the advantages of early retirement and are over the age of 45, respond today to find out how this program can be "tailor-made" to fit *your* specific needs. Please contact Ms. Dalal Salomon at (804) 782-3478 or 1-800-999-4328, or return the coupon below.

*This program is available for Defined Benefit Plans, Profit-Sharing Plans, Keoghs, 401(k), IRAs, any other retirement plans or any other qualified distributions.

YES, I'm interested in finding out how I can access my retirement income without **incurring IRS penalties** for early withdrawals.

☐ Please send me more information.

☐ Please call me immediately (Best time to call is _____ am/pm).

☐ Please schedule an appointment with me at my _____ home _____ office.

Date _____ Time _____

Name _____ Daytime Phone _____

Address _____ Age _____

Return to: Ms. Dalal Saloman, Wheat, First Securities
707 E. Main Street, Richmond, VA 23219

REFERENCE COMMITTEE THREE: Internal Affairs

Carol S. Shapiro, MD, Chairman
James A. Wassum, MD, Robert T. Mosby, MD,
Emerson D. Farley, Jr., MD, Anthony J. Munoz, MD,
Charles C. Freed, MD, Robert L. A. Keeley, MD,
Harvey D. Smallwood, MD, C. Robert Meloni, MD,
William R. Deal, MD, and Sterling Ransome (Student)

Animal Research

On the recommendation of the Reference Committee, the House adopted without discussion a resolution from the Animal Research Committee asking **that the Medical Society of Virginia support legislation making it a federal crime to attempt to damage or destroy any animal research facility.**

Consent Calendar

Reference Committee Two recommended the adoption on a consent calendar basis of the following three items, and the House so adopted.

1) A resolution on health care savings accounts from the Virginia Academy of Family Physicians, reading:

Resolved, that the Medical Society of Virginia support the concept of health care savings accounts as outlined in HR 1080 of the 101st Congress and urge MSV members to contact their respective senators and congressmen in support of this bill, and

Resolved, that the Medical Society of Virginia provide pertinent information concerning HR 1080 to its membership to assist them with the composition of correspondence on this matter to their respective senators and congressmen.

2) Also from the VAFP, a resolution on laboratory testing:

Resolved, that the Medical Society of Virginia go on record as being opposed to existing federal regulations which require physicians to accept assignment for clinical laboratory services, and

Resolved, that the Medical Society of Virginia request the American Medical Association to work for the repeal of federal regulations which require physicians to accept such assignment and support development of alternative regulations making appropriate provisions for laboratories in physician offices.

3) The Report of the Committee on Alternative Delivery Systems.

Deunification

To the members of Reference Committee Three had been given the question of MSV/AMA deunification. Four pertinent documents were theirs for study: 1) the Report of the Society's Committee on Unification/Deunification, advocating reevaluation by the House of its 1985 unification decision; 2) a resolution from the Williamsburg-James City County Medical Society asking for repeal of unification; and 3) the Report of Council, calling for a vote of the membership, with proxy votes as legal tender, on a resolution to deunify. The Council backed up its recommendation by citing the "tremendous loss in membership and income over the past four years of unification" and the overwhelmingly negative comments on unification written into the responses to the 1989 Physicians Opinion Survey (Va Med Oct 1989).

Testimony at Reference Committee Three's hearings bore out and enlarged upon the councilors' concerns. Even Dr. William S. Hotchkiss, the most recent (1987–88) of Virginia's five AMA presidents, had regretfully concluded, he told the Reference Committee, that the Society simply had to deunify, the issue had become too divisive. Meantime, it was bruited about the Richmond Marriott's hallways that the proxy ballots sent out early in October on Council's authorization had brought in an overwhelmingly pro-repeal vote.

Taking all the material and testimony into account, Reference Committee Three decided to revise the Williamsburg-James City County Medical Society's resolution to read as follows:

Resolved, that the House of Delegates determines that the proposed amendment of the Articles of Incorporation of the Medical Society of Virginia to delete the requirement that dues-paying active members must be members of the American Medical Association is of sufficient importance to the Society that it should be submitted to a vote of the voting members of the Society at the meeting to be held on November 11, 1989, and that proxy voting should be permitted at that meeting.

When Chairman Carol Shapiro read out the recommendation to adopt, only one delegate rose with a caveat: Since unification had been adopted by a vote of the House, he said, shouldn't the House make any decision to deunify? Swiftly rejecting this idea, the delegates adopted the resolution as read.

Thereupon Speaker George Broman yielded the podium to Presiding Officer Tom Hulvey, who called to order a meeting of the membership, appointed election inspectors, and ordered the distribution of ballots to those who had not sent in proxies. There were questions from the floor. "Is this entirely legal?" Absolutely, Dr. Hulvey assured the delegates; every step had Counsel Allen

Medical Society of Virginia 1989-1990 Officers and Councilors

President	**William H. Barney, MD,** *Lynchburg*
President Elect	**John A. Owen, Jr., MD,** *Charlottesville*
Past President	**J. Thomas Hulvey, MD,** *Abingdon*
First Vice President	**Leon I. Block, MD,** *Falls Church*
Second Vice President	**William W. Regan, MD,** *Richmond*
Third Vice President	**William H. Sipe, MD,** *Newport News*
Speaker of the House	**George E. Broman, MD,** *Culpeper*
Vice Speaker	**Lawrence K. Monahan, MD,** *Roanoke*
Councilors	1st District: **Louis D. Parham, MD,** *Hampton*
	2nd: **Russell D. Evett, MD,** *Norfolk*
	3rd: **James A. Shield, Jr., MD,** *Richmond*
	4th: **John W. Hollowell, MD,** *Portsmouth*
	5th: **Edwin J. Harvie, Jr., MD,** *Danville*
	6th: **Jeffrey W. Wilson, MD,** *Lynchburg*
	7th: **H. George White, Jr., MD,** *Winchester*
	8th: **Ira J. Green, MD,** *Alexandria*
	9th: **James L. Patterson, Jr., MD,** *Pulaski*
	10th: **Ira D. Godwin, MD,** *Fairfax*
Vice Councilors	1st District: **Norman R. Edwards, MD,** *Newport News*
	2nd: **Clarke Russ, MD,** *Virginia Beach*
	3rd: **Lawrence E. Blanchard III, MD,** *Richmond*
	4th: **Charles H. Crowder, Jr., MD,** *South Hill*
	5th: **James E. Nevin, MD,** *Danville*
	6th: **Kenneth D. Tuck, MD,** *Roanoke*
	7th: **Norris A. Royston, MD,** *Marshall*
	8th: **Carol S. Shapiro, MD,** *Woodbridge*
	9th: **Palmer W. Fant, MD,** *Independence*
	10th: **Gordon L. Avery, MD,** *Arlington*
Councilors Ex Officio	**C. M. G. Buttery, MD,** *Richmond*, State Commissioner of Health
	Edwin L. Kendig, Jr., MD, *Richmond*, Editor, VIRGINIA MEDICAL
AMA Delegates	**H. C. Alexander III, MD,** *Roanoke*
	Raymond S. Brown, MD, *Gloucester*
	Charles M. Caravati, Jr., MD, *Richmond*
	C. Barrie Cook, MD, *Falls Church*
	Richard L. Fields, MD, *Fairfax*
	William J. Hagood, Jr., MD, *Clover*
	John A. Martin, MD, *Roanoke*
	Harold L. Williams, MD, *Newport News*
	Percy Wootton, MD, *Richmond*
Alternates	**James P. Baker, MD,** *Norfolk*
	H. Alan Bigley, Jr., MD, *Petersburg*
	Leon I. Block, MD, *Falls Church*
	George E. Broman, MD, *Culpeper*
	George J. Carroll, MD, *Suffolk*
	Joseph H. Early, Jr., MD, *Hillsville*
	Russell D. Evett, MD, *Norfolk*
	James A. Shield, Jr., MD, *Richmond*
Executive Vice President	James L. Moore, Jr. Emeritus, Robert I. Howard

THE MEDICAL SOCIETY OF VIRGINIA • 4205 DOVER ROAD • RICHMOND, VIRGINIA 23221 • (804) 353-2721

Goolsby's seal of approval. "May I change my proxy vote?" You most certainly can, Dr. Hulvey responded, by filling out one of the ballots being circulated and noting on it that it replaces a proxy vote. The ballots were collected, the membership meeting was adjourned, the House of Delegates resumed its deliberations.

Half an hour later the inspectors came back with the count and Dr. Hulvey read out the figures: 2,962 (89%) for deunification, 370 (11%) against.

Impaired Physicians Program

Reference Committee Three recommended the adoption of the request from the Physicians' Health and Effectiveness Committee for a budget of $18,000. The House adopted the recommendation.

Adopted also was Reference Committee Three's recommendation "Dr. William Barney be commended for his pioneer work and leadership with the Physicians' Health and Effectiveness Committee and that the efforts of Dr. David Fluharty, who has made this committee a role model in this country, be applauded". The delegates rose to their feet to commend and applaud. Earlier, Dr. Barney had been elected President of the Medical Society of Virginia 1989–1990 (see page 00).

Dr. Fluharty had introduced a resolution on the AMA's funding of the Impaired Physicians Program, and the Reference Committee recommended its adoption with slight amendments, as follows:

Resolved, that the Medical Society of Virginia recommend to the American Medical Association that it continue to adequately fund and maintain an impaired physicians program ("Physicians Assistance Program"), whose ~~charge~~ responsibilities will include, but not be limited to, promoting state medical society impaired physician programs, providing technical assistance to these programs, conducting scientific and socioeconomic research, and hosting an annual conference to share research, exchange ideas and provide educational opportunities in the field of physician impairment.

The resolution was adopted as amended.

The tellers go over the arithmetic of the deunification balloting. Clockwise from left, Dr. Joel R. Poole, Culpeper, Dr. Jack C. Turner, Danville, Dr. William W. Gough, Norfolk, Dr. John W. Knarr, Pulaski, Chairman, and Dr. Monroe G. Baldwin, Lynchburg.

Bylaws

Dr. Shapiro reported that Reference Committee Three recommended adoption of the first item in the Supplemental Report of the Bylaws Committee asking that the name of the Public Relations Committee be changed to the "Public Relations and Communications Committee." Instead of adopting, the House elected to refer the recommendation to Council.

A second recommendation from the Bylaws Committee asked for "an extensive revision" of the bylaws. The Reference Committee amended the measure as follows:

Resolved, that the Bylaws Committee undertake a comprehensive review of the bylaws of the Medical Society of Virginia in the coming year.

The House of Delegates adopted the recommendation as amended.

Budget

The Reference Committee recommended the adoption of the 1989–90 Proposed Budget (see page 00), said the Chairman, and the House adopted it forthwith.

Consent Calendar

Reference Committee Three recommended the adoption on a consent calendar basis of the Report of the Bylaws Committee and the Report of the Membership Committee. The House adopted both reports.

Fifty-Year Club

For thirty Medical Society of Virginia members, 1989 marked the 50th anniversary of graduation from medical school, thus qualifying them for the 50-Year Club. They were invited to a reception in their honor at the annual meeting, and the eight physicians shown here attended that reception. Seated at center is Dr. Levi W. Hulley, Jr., Richmond. Standing on either side of him are, from left, Dr. Irving Berlin, Hampton; Dr. John H. Thomas, Jr., Greenville; Dr. Saul Kay, Richmond; Dr. William S. Hotchkiss, Chesapeake; and Dr. John Schurr Snider, Irvington. At rear are Dr. J. Warren Montague, Richmond (left), and Dr. Claude Porter Sherman, Martinsville. Here are the new members who were not present for the photograph:

Theodore Bliss III, MD, Norfolk
Beverley B. Clary, MD, Richmond
Jose D. Coll, MD, Richmond
Wayne A. Geib, MD, Albuquerque, New Mexico
Garrett G. Gooch III, MD, Salem
Asa Wesley Graves V, MD, Lacey Spring
T. Ham, MD, Vienna
John C. Hortenstine, MD, Stuart, Florida
William H. Hosfield, MD, West Point
Lawrence A. Jacklin, MD, Falls Church
L. Meredith Johnson, MD, Asheville, North Carolina
Delmas Bernard Jones, MD, Eureka, California
Robert C. Longan, Jr., MD, Richmond
O. Hunter McClung, Jr., MD, Lexington
Vito J. Murgolo, MD, Silver Spring, Maryland
John L. Patterson, Jr., MD, Richmond
Robert L. Payne, Jr., MD, Norfolk
Nelson Podolnick, MD, Falls Church
Japheth E. Rawls, Jr., MD, Suffolk
Maurice R. Schlanger, MD, Portsmouth
McKelden Smith, MD, Staunton
Lewis Frank Somers, MD, Lynchburg
Mario Stefanini, MD, Richlands

VIRGINIA MEDICAL

Hooray and Hullelujah

UNIFICATION is dead. The ill-fated attempt of the Medical Society of Virginia to require the membership to also become dues-paying members of the American Medical Association has led to wholesale resignation, a membership loss estimated at 1,700 to 2,000. At the 1989 annual meeting, a vote of the Medical Society of Virginia membership favored deunification by a margin of eight to one. (See page 27.) If unification has been the real or major cause of membership loss, the Society will soon regain its former strength. Let us hope this is the case.

The idea behind unification was, and is, a good one. For greatest effectiveness, medicine must speak with one voice, and the organization best equipped to be that voice is the American Medical Association. The drawbacks are obvious: No one likes to be coerced, and of course, for young practitioners and those in low income specialities, the additional dues can be a burden.

Let us all remember one essential fact: Physicians must resist the divide-and-conquer tactics of government and big business. This can be accomplished only if we work together.

E.L.K., Jr.

Dr. Barney Takes Charge

Following are excerpts from the inaugural remarks of the Medical Society of Virginia's new President, Dr. William H. Barney, before the House of Delegates at the annual meeting.

"The Neurologically Damaged Infant Act has been an anathema to many of our physicians. This is a very disturbing situation to me. We will continue to work to improve this act and to get the assessment removed. . .

"A committee of great importance this past year is one chaired by Dr. Charles Caravati to develop a better relationship with the Blue Cross/Blue Shield board, and these two groups, MSV and BC/BS, have done just that. In the area of electronic billing alone, negotiations have saved Virginia physicians literally hundreds of thousands of dollars. I have asked that this committee expand its mission to work with other insurance carriers when problems arise. It will be renamed the Committee on Third-Party Payers and will be chaired by Dr. Latane Ware. . .

"Perhaps we have not adequately dealt with the increasing problem of illegal drugs and related crimes . . . I believe that our voice can be important, especially in the areas of education and legislation, and I have appointed a new Committee on Substance Abuse, chaired by Dr. Mike Bohan, to study this problem and advise Council and the House of any action that might help. . .

"I am convinced that we are closer now to national health insurance than we have been in the 45 years that I have been involved in medicine. . . . Let us make certain that our voice is heard through the Federal Legislative Committee under Dr. Norman Edwards working with our congressmen and through the influence of our delegates to the AMA."

PRESIDENTIAL ADDRESS

"We must join hands to find answers."

J. Thomas Hulvey, MD, President 1988-1989,
The Medical Society of Virginia

When I became President of the Medical Society of Virginia, I had a number of things I hoped we could accomplish. We did take many substantial strides forward, but I can't begin to talk about them without acknowledging the people in the MSV organization who have done so much to make those strides possible.

First of all, neither I nor any other MSV President in recent memory could have accomplished anything at all without the unfailing help of our headquarters staff. In particular, my heartfelt thanks to Jim Moore, who is intuitive, has the patience of Job and the very best interests of the Society at heart, and to Ann Gray, who has for years produced an outstanding medical journal on a shoestring and is now making retirement noises. Heaven help us if she really does retire. The MSV staff is small by medical society standards, but they are first rate from top to bottom, and we are very much in their debt.

Now back to what's happened this year—and it's been quite a year. When I started out, I set two major goals—to rebuild the MSV membership and to try to remove the nonobstetric physicians from the annual $250 assessment. While I didn't reach the final goal on either, in spite of considerable effort, I am very proud to say that we've laid the foundation for both of these goals to be met in the near future. Let me explain.

You don't need to be told the rate at which we've been losing members. The losses this year were the heaviest since the first year of unification. We thought we knew the basic reasons why, but we weren't positive. So we did a survey of all the physicians in the state. I'm sure you've seen the reports of the results in Virginia Medical. They are astounding.

Of approximately 11,000 surveys sent out, over 6,000 completed forms were returned to us. Although many of the responses were critical of some of our policies and of our image, we were greatly encouraged that so many Virginia physicians cared enough to respond. We've already started to take action on what they told us.

The survey also gave us a lot of additional useful information about what all physicians throughout the state think of The Medical Society of Virginia. We gained invaluable insight into ways we might better serve our members. More importantly, we've learned that we must make a better effort to tell everyone about our programs and solicit their input. We thought that was what we were doing. The survey told us otherwise.

As physicians, we know all too well that we can't treat a disease very effectively until we have established a diagnosis. And so, while I was not able to resolve the membership crisis, I am very pleased to have been President when the diagnosis was found, and we have begun to treat the problem. The real work of implementing what we've learned falls to my very capable successor.

As for Injured Infants Act assessment, we gave it our all and did succeed in getting the General Assembly to authorize a study to improve and broaden the definition of the Act and the financing of the program. We believe that this will soon result in the removal of the assessment and improvement of the overall program as well. Without such a study to use as a basis, there simply was no enthusiasm in the legislature for removing the assessment.

We've done much more in other areas during the year, too. We produced a *Directory of Virginia Physicians* and supported many worthwhile projects, but among the most far-reaching work we've done this year, in terms of providing long-term solutions to a number of problems, is with the state government. Our relationship with our state officials this year has been excellent, and our recommendations have been warmly received by the Governor and the leadership.

A good example is our efforts in the area of indigent care. During my first week in office, I appointed an Indigent Care Committee, which has worked very closely with the Commissioner of Health and the Department of Health and Human Services.

One of the major problems facing this committee is that of indigent mothers who have difficulty finding an obstetrician to deliver their babies. I am certain there is not a physician present who is not concerned about this problem. This committee and the leadership of this Society continue to meet with Commissioner Buttery, with Secretary Teig, and with the leaders of the various specialty societies in an attempt to solve this dreadful crisis. We know we cannot replace those family practitioners and senior obstetricians who have given up obstetrics because of the malpractice crisis and the problems inherent in the practice of rural and intercity obstetrics, and since these problems will not go away on their own, we're looking for other solutions.

Another example of this cooperation with state government is in the area of health care for our senior citizens. They want and need quality heatlh care at an affordable price. In part because of the growing numbers of elderly and resulting costs of providing for their health care, we are now facing a series of challenges that threaten ultimately to replace our health care delivery system with one that may, for the sake of economy, assume the appearance of the Canadian health system and will likely result in the rationing of health care for the first time on a large scale to a select group of patients—our senior citizens.

In addition to our work with state and local government in this area, many of our local medical societies have taken the initiative and are actively working to assure that the elderly receive affordable quality health care in their communities.

We are all painfully aware of today's very important health care issues. We know that there are 26 million uninsured workers in the USA. We know that the infant mortality rate is far above where it could and should be. We are suddenly aware that the incidence of AIDS amongst our teenagers is skyrocketing, and the problem of drugs in our society exacts a staggering price. These are problems that must be dealt with, and we in the medical community as individual physicians and as a Society must take an active and visible role.

Our survey showed us that our members—and also, I might add, prospective members—look to organized medicine to represent them with government at all levels as these critical issues are addressed. While we in this Society know we have been working hard, we must continue to do so and to draw in our colleagues to help. No one can be allowed to sit idly by and let the government make all of the health care decisions.

It is up to us to see that this does not happen. We have a lot to offer, and we must continue to be available to provide our input and expertise and to demonstrate our resolve to find solutions. I believe that we will be more than welcome, at least at the state level. We must not leave health care planning in the hands of those who are responsible for the postal service, Social Security, and Medicare.

It has been a great honor to serve as President of this Society. I believe that during this past year, in spite of our difficulties, we have established an important link to those physicians in Virginia who do not belong to this Society by asking for their views and their input and by responding visably and positively. I hope that we will continue to ask periodically for input from members and nonmembers alike.

There is much to do. We must rebuild our membership, put sdide our internal differences, and join hands to find answers to the very serious health care problems that face us.

I thank you for your help and cooperation during this past year and for giving me the opportunity to serve you. It has been an exciting and educational experience.

MEETINGS

January 20
Meeting of the Medical Society of Virginia Council, *Richmond*. James L. Moore, Jr., (804) 353-2721.

January 23
Cancer Detection and Prevention (Fairfax Hospital), *Falls Church*. 3.5 credit hrs. Fee, $40. Cathy Sarraf, 703-698-2572.

January 25-28
24th Annual Meeting of the Neurosurgical Society of the Virginias, the Homestead, *Hot Springs*. Dr. George W. Johnson, 804-320-2758.

January 26
2nd Conference on Comprehensive Care of the Diabetic and Geriatric Foot (Eastern Virginia Medical School), *Virginia Beach*. CME Office, 804-446-6140.

January 27-February 1
Clinical Problems in Gynecologic Surgery (John Hopkins/Emory University/Brown University), St. Thomas, Virgin Islands. 20 credit hrs. Fee: $475. CME Office, 301-955-2959.

January 28-February 2
Gastroenterology Update 1990 (Johns Hopkins/American College of Gastroenterology), *Park City, Utah*. 20 credit hrs. Fee, $400. CME Office, 301-955-3839.

January 29-21
How to Get Started in Medical Practice: A Practice Management Workshop for Residents (Southern Medical Association), *Richmond*. 1-800-423-4992.

February 2-4
Annual Meeting of the Virginia Neurological Society, *Williamsburg*. Donna Scott, 804-353-2721.

February 18-25
12th Annual Wilmer Institute Current Concepts in Ophthalmology (Johns Hopkins), *Dorado, Puerto Rico*. 30 credit hrs. Fee, $475. CME Office, 301-955-2959.

February 23-25
Pediatric Emergency Medicine (Virginia Chapter, American Academy of Pediatrics, and Virginia Pediatric Society), Conference Center, *Williamsburg*. 13 hrs. credit. Judy Suher, (804) 643-8130.

February 25-March 3
4th Annual Innovations in the Diagnosis and Treatment of

LONG-TERM CARE: IN SIXTH DECADE OF EXCELLENCE

The Windsor
Accredited by JCAH
3600 Grove Ave., Richmond VA 23221
804 353-3881

Mrs. Plyler's
Residential Care
1615 Grove Ave., Richmond VA 23220
804 353-3981

University Park
Accredited by JCAH
2420 Pemberton Rd., Richmond VA 23233
804 747-9200

Announcing
Lloyd Noland

Continuing Medical Education Postgraduate Courses

at three attractive locations

at The Grosvenor Resort, Walt Disney World, Lake Buena Vista, Florida:

Internal Medicine Seminar
March 11-14, 1990

Pediatrics Seminar
March 14-17, 1990

Pediatric Infectious Disease Seminar
"Fall Update"
October 17-20, 1990

at Sea Pines Plantation, Hilton Head Island, SC:

General Surgery Seminar
"Update and Review"
June 4-8, 1990

Family Practice Seminar
"Update and Review"
June 26-30, 1990

Orthopaedic Sports Medicine Seminar
July 5-8, 1990

Adult Infectious Disease Seminar
"Current Update"
June 11-15, 1990

Pediatric Infectious Disease Seminar
"Current Update"
June 19-23, 1990

Advances in Cardiology
July 9-13, 1990

at The Greenbrier, White Sulphur Springs, WV:

Advances and Controversies in Internal Medicine Seminar
November 1-4, 1990

Call or write the Office of Medical Education,
Lloyd Noland Hospital
701 Lloyd Noland Parkway, Fairfield, Alabama
for details and brochures.

Telephone (205) 783-5276

Lloyd Noland Hospital is **ACCME accredited** and programs are approved for PRA-AMA and AAFP credit.

Advice to Authors

Copyright of an article published in VIRGINIA MEDICAL is retained by the author, but the copyright to each entire issue as a collective work is the property of The Medical Society of Virginia, and permission to reprint all or any part of a published article must be negotiated with the author and the Editors jointly. The reprinted material must carry a credit line signifying that it first appeared in VIRGINIA MEDICAL.

Manuscript Preparation

Medical articles, editorials, essays, Letters to the Editor and all other text submitted for publication must be double-spaced throughout, including references, legends and all other elements. The material should be typed on one side of the paper, with generous margins of at least 1¼ inches all around. Do not use all-caps or a script typeface. Submit one original of the communication and one copy. If the material is not accepted, the original will be returned; the copy will be retained.

The author is responsible for the accuracy of all statements and references. Acronyms and other abbreviations should be kept to a minimum; unless an acronym is widely known and used by all specialties, it should be fully explained in the text. Refer to pharmaceutical products by their generic names; brand names may follow in parentheses and should carry registered trademarks where applicable. All units of measure should appear in the metric system. References, typed in double-space, should be listed in the order of their citation in the text, not alphabetically. They should follow VIRGINIA MEDICAL's typographic style for references; the typist should study this style as it appears in each issue.

Illustrations should be black and white glossy prints, with legends typed in double-space on a separate sheet of paper. VIRGINIA MEDICAL has no budget for printing in color; the author who wishes to publish a four-color figure may negotiate to pay for the costs.

Attach to the contribution a covering letter giving the address and telephone number of the person who will correspond about it and address the completed communication to the Editors, VIRGINIA MEDICAL, 4205 Dover Road, Richmond VA 23221.

All manuscripts are subject to editorial changes. If extensive revision is deemed necessary, the author will receive for approval a draft of the article as edited.

There are many excellent handbooks of effective writing, among them *The Elements of Style*, by William Strunk, Jr., and E. B. White (MacMillan); *The Careful Writer: A Modern Guide to English Usage*, by Theodore M. Bernstein (Atheneum); and *How to Write and Publish a Scientific Paper*, by Robert A. Day (ISI Press).

Gastrointestinal Disorders (Georgetown University), *Vail, Colorado*. CME Office, 202-687-8735.

March 3
4th Annual Peripheral Vascular Disease Symposium (Fairfax Hospital/Georgetown University), *Falls Church*. 3 credit hrs. Fee, $40. Cathy Sarraf, 703-698-2572.

March 5-8
Alton D. Brashear Postgraduate Course in Head and Neck Anatomy (Medical College of Virginia/VCU), *Richmond*. Hugo R. Seibel, PhD, 804-786-9624.

March 8-11
Controversies in Obstetrical Ultrasound (Eastern Virginia Medical School), *Snowbird, Utah*. 16 credit hrs. CME Office, 804-446-6140.

March 10-17
7th Annual Wilmer Institute Current Concepts in Ophthalmology (Johns Hopkins), *Vail, Colorado*. 30 credit hrs. Fee, $475. CME Office, 301-955-2959.

March 11-14
Internal Medicine Seminar (Lloyd Noland Hospital), Disney World, *Lake Buena Vista, Florida*. CME Office, 205-783-5276.

March 14-17
Pediatrics Seminar (Lloyd Noland Hospital), Disney World, *Lake Buena Vista, Florida*. CME Office, 205-783-5276.

March 19-21
Spectrum of Developmental Disabilities XII: Prematurity—Neuro-Developmental Assessment and Intervention Issues (Kennedy Fellows Ass'n/Kennedy Institute Handicapped Children/Society Developmental Pediatrics/Johns Hopkins), *Baltimore*. 20 credit hrs. Juliet M. Nutt, 301-550-9423.

March 23
Sleep Apnea (Eastern Virginia Medical School), *Norfolk*. CME Office, 804-446-6140.

March 24-25
Advanced Cardiac Life Support Provider Course (Fairfax Hospital), *Falls Church*. Fee, $200. Cathy Sarraf, 703-698-2572.

March 30-April 1
Pediatrics 1990 (American Academy of Pediatrics), *Marco Island, Florida*. Suzanne Goheen, 312-981-7884.

April 6-8
Mammography: Current Concepts and Interpretation (Eastern Virginia Medical School), *Williamsburg*. CME Office, 804-446-6140.

April 6-8
Annual Ophthalmology Conference: Cornea and External Disease (Medical College of Virginia/VCU), *Williamsburg*. CME Office, 804-786-0494.

YOU WORRY ABOUT PATIENTS

LET US WORRY ABOUT YOUR PRACTICE

YOUR COLLECTIONS

YOUR GROWTH

YOUR CASH FLOW

YOUR STATISTICS

YOUR BILLING

YOUR FINANCES

YOUR PAYROLL

YOUR FUTURES

At Integrated Office Solutions, Inc. (IOS), we provide financial security for practices through our sophisticated medical management software. This software combines the latest methods of user friendly software techniques to offer a fully integrated management system designed exclusively for physicians. The benefits ensure increased productivity, organization, and accuracy. More importantly, month end close and insurance billing is decreased to several hours, instead of several days.

Benefits of automation: **Improve cash flow monitoring**
Raise collection percentage
Organize financial information for CPA's
Provide practice analysis for growth and future

IOS has taken a position to build on our reputation of outstanding service and unprecedented support of our clients. Our continued success depends on providing your practice with the best medical software now and in the future. Our selection as an Agent and Business partner with IBM is also an indication of the confidence IBM has in our software and our company's ability to install and support the AS/Entry and AS/400 family of computers.

Go ahead, let IOS and IBM worry about your practice. Call today for a no charge survey and analysis of your computer needs. Remember, when you automate your practice, you will have more time to worry about others. (Your patients will love you.)

Integrated Office Solutions, Inc.

1603 Santa Rosa Rd.,
Suite 108
Richmond, Virginia 23229
(804) 282-3785

IBM Business Partner
Authorized Agent

THE MEDICAL SOCIETY OF VIRGINIA ANNOUNCES EXCITING, NEW 1990 INTRAV Adventure Programs

IMPORTANT! Although the Medical Society will block space on one departure date per Adventure, INTRAV operates several departures of all its tours. If the date the Medical Society chooses is not convenient for you, call INTRAV at 1-800-234-6900, and ask for alternate departure dates.

WINTER/SPRING

Amazon River and Grenadine Islands

Eleven Days
An exciting new Air/Sea Cruise aboard Sun Line's five-star ***Stella Solaris***. Cruise from the heart of the **Amazon** in **Manaus** to **Alter Do Chao** and **Santarem** to the **Grenadines: Tobago, Trinidad, Grenada** and **Barbados**.
From $2499 per person, double occupancy from Miami

Mexican Riviera Air/Sea Cruise

Eight Days
FREE AIRFARE TO LOS ANGELES
Cruise the Mexican Riviera. Sail from convenient **Los Angeles** aboard the ***Fair Princess*** to **Cabo San Lucas**, Baja; **Mazatlan** and **Puerto Vallarta**.
From $1035 per person, double occupancy from most U.S. cities

South American Adventure

Sixteen Days
Lima and **Cuzco/Machu Picchu**, Peru. **Buenos Aires**, Argentina. **Iguassu Falls** and **Rio de Janeiro**, Brazil. Special highlights include a walking tour of Machu Picchu, tour of Iguassu Falls and parties.
$3099 per person, double occupancy from Miami

South Pacific

Seventeen Days
Two-night pretrip option in **Nandi**, Fiji. **Auckland, Rotorua** and **Queenstown**, New Zealand, with full-day included sightseeing in **Christchurch. Sydney** and **Cairns**, Australia, with a full-day included tour of **Green Island** and the **Great Barrier Reef**.
$3999 per person, double occupancy from Los Angeles

SUMMER

Romantic Rivers and Castles

Fourteen Days
A dramatic itinerary to a Europe most travelers miss. **Brussels**, Belgium. **Six-night cruise** aboard the chartered ***M.S. Olympia*** on the **Mosel, Rhine** and **Main Rivers** from **Trier** to **Bernkastel, Cochem, Koblenz, Rudesheim, Heidelberg, Miltenberg, Wertheim, Wurzburg** and **Rothenburg. Munich,** West Germany.
From $2899 per person, double occupancy from New York (JFK)

Europe: East and West

Fourteen Days
A study in contrasts of West and East...**West Berlin**, West Germany. **Prague**, Czechoslovakia. **Budapest**, Hungary. **Vienna**, Austria. The best way to see Eastern Europe.
$2999 per person, double occupancy from New York (JFK)

FALL

Wings Over The Himalayas

Eighteen Days
The best of the extraordinarily different world of China, Tibet and Nepal—at the very best time of year. **Beijing** (Peking), **Xian** and **Chengdu**, China. Lhasa, **Tibet**. Katmandu, **Nepal. Hong Kong. All sightseeing included in China and Tibet.**
$4399 per person, double occupancy from Los Angeles.

Russian Adventure

Thirteen Days
Helsinki. Overnight aboard the famous ***Tolstoi Express*** train en route to **Leningrad**, U.S.S.R. **Kiev. Moscow. All meals, cocktail parties and sightseeing included, plus a full-day included excursion to Zagorsk.**
$2899 per person, double occupancy from New York (JFK)

Please Note: All prices quoted are approximate and subject to change.

FOR MORE INFORMATION, SEND COUPON TO

The Medical Society of Virginia
Mrs. Margaret Brown
4205 Dover Road
Richmond, VA 23221
Or call (804) 353-2721

Yes, I want to get away in 1990! Please send me brochures on the following programs as soon as they become available:

- ☐ Amazon River/Grenadines
- ☐ Romantic Rivers and Castles
- ☐ Mexican Riviera
- ☐ Europe: East & West
- ☐ South America
- ☐ Wings Over the Himalayas
- ☐ South Pacific
- ☐ Russia

Name_____

Address _____

City_____

State_____ Zip Code_____

Area Code (___)_____ Office Phone_____

Area Code (___)_____ Home Phone_____

MORE THAN **250,000** PATIENTS HAVE ENJOYED HEALTH BENEFITS RESULTING FROM MEDIFAST.

MORE THAN **10,000** PHYSICIANS PRESCRIBE MEDIFAST WITH CONFIDENCE.

MORE THAN **10** YEARS OF DEDICATED SERVICE TO THE MEDICAL PROFESSION.

No Other Physician-Supervised Weight Control Program Delivers This Winning Combination

...and that makes Medifast #1

Physician-Supervised Protein-Sparing Modified Fast For the Safe • Rapid • Medical Treatment of Obesity

Doctor, one of every four of your patients has overweight problems that need medical help...the help of Medifast®.

A comprehensive program for rapid weight loss *and lifelong weight control,* Medifast has proven itself. For more than 10 years! To more than 10,000 physicians! To more than 250,000 patients!

TRAINING MANUALS

Medifast will work for you, too.

Patients lose weight with a program of physician-supervised modified fasting and behavior modification. And they keep it off with our exclusive *LifeStyles* Program.

The Medifast Program includes:

★*Training* – Comprehensive training manuals written by physicians, for physicians. Address all clinical and administrative aspects.

★*Medifast Supplements* – Extremely high quality. Medically formulated. Nutritionally complete.

★*LifeStyles* – The Medifast Program of Patient Support™. Teaches patients the way to long-term weight control and healthful living.

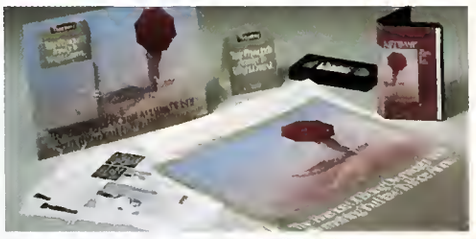
★*Clinical Consultation* – Medical and technical support specialists available daily at our toll-free number.

★*Practice Promotion Portfolio* – Complete with marketing ideas, office displays, posters, waiting room brochures, and advertising.

★*National Consumer Ad Campaign* – Builds public awareness, creates referrals.

LifeStyles; PATIENT SUPPORT

You know, Doctor, that more traditional methods of weight reduction are simply ineffective. And, severe overweight threatens your patient's health. Primary Care Physicians of every specialty recognize Medifast to be an important addition to their prescribed therapy and an effective way to increase their patient base.



PROMOTION PORTFOLIO

For complete information call toll-free

1-800-638-7867

For more information about the Medifast Program, please send this coupon to:

The Nutrition Institute of Maryland
William J. Vitale, M.D.
Director, Clinical Services
1840 York Road, Suite H
Timonium, MD 21093

NAME

ADDRESS

CITY STATE ZIP

PHONE SJG-12

MEDIFAST

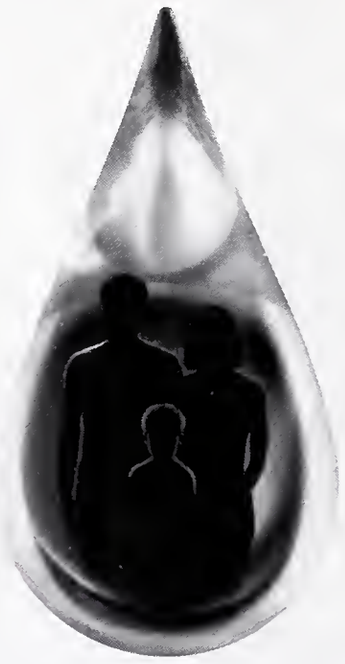
The Physicians' Answer to Weight Control

©Jason Pharmaceuticals 1989

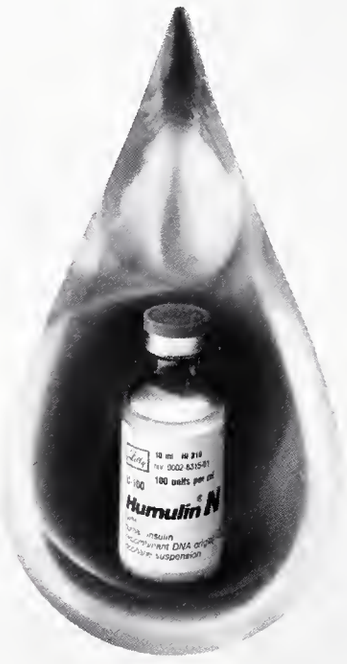
For treatment of diabetes:

Introducing
Humulin® 70/30
70% human insulin isophane suspension
30% human insulin injection
(recombinant DNA origin)

REPLACE
Human Insulin



With Human Insulin



Humulin®
human insulin
(recombinant DNA origin)

Any change of insulin should be made cautiously and only under medical supervision.

Lilly
Leadership
In Diabetes Care

© 1989, ELI LILLY AND COMPANY HI-2914-B 949334

FOR SALE

4301 Meadowdale Boulevard

(Located off Hopkins Road and Chippenham Parkway)

- ★ 11,300 SQUARE FEET; 2.29 ACRES WITH BUILDING EXPANSION CAPABILITY
- ★ COMPLETELY EQUIPPED FOR GENERAL MEDICAL AND DENTAL PRACTICES
- ★ LOCATED IN A GROWTH CORRIDOR IN CHESTERFIELD COUNTY NEAR ROUTE 288 AND I-95

CALL: WENDY FRICKE

804/788-1000 ■ FAX 804/782-1145

Harrison & Bates
INCORPORATED

NEW AMERICA NETWORK

First National Bank Building ■ Suite 1800
823 E. Main St. ■ Richmond, VA 23219-3308
804/788-1000 ■ FAX 804/782-1145

NOTE: This offering subject to errors, omissions, prior sale or withdrawal without notice.

VaMPAC

VaMPAC

AMPAC

Major concerns affecting the medical profession are decided in the political arena and VaMPAC needs your membership to financially support campaigns of legislative candidates, and reflects your commitment to political action. VaMPAC can influence the political and legislative decisions that determine the practice of medicine in the Commonwealth. We can ensure that our legislators receive the best advice on actions that affect our patients and our profession. Medicine's views on these important issues are critical to ensuring that good legislation becomes law—and that bad legislation doesn't.

VaMPAC is the political action committee of The Medical Society of Virginia. Enclosed is a check for:

☐ **$100 for a Sustaining Membership, or**

☐ **$250 for a PAC 250 Membership that includes your spouse.**

Name _____

Address _____

City _____

State _____ Zip _____

Spouse _____

All memberships include annual membership in AMPAC.

NEW MSV MEMBERS

Chesapeake Medical Society

Prudencio Mendez, Jr., MD, Head and Neck Surgery, 2147 Old Greenbrier Road, Chesapeake VA 23320

Fairfax County Medical Society

C. Darcy Blair, MD, Internal Medicine, 311 Park Avenue, Falls Church VA 22046

Gregory A. Neas, MD, Head and Neck Surgery, 13705 Stonedale Court, Clifton VA 22024

Northern Virginia Medical Society

James S. Wiedower, MD, General Surgery, 116 South Stewart Street, Winchester VA 22601

Portsmouth Academy of Medicine

Nam Hyun Chough, MD, Anesthesiology, 3640 High Street, Portsmouth VA 23707

Wayne R. DeVantier, MD, Ophthalmology, 3603 County Street, Portsmouth VA 23707

Richmond Academy of Medicine

Bruce S. West, MD, Pediatrics, PO Box 13170, Richmond VA 23225

Southwestern Virginia Medical Society

Gerald Zel, MD, Urology, 2460 Lee Highway, Pulaski VA 24301

Tazewell County Medical Society

Ronald C. Sherowsky, MD, Diagnostic Radiology, PO Box 785, North Tazewell VA 24630

Tri-County Medical Society

Deborah J. Presnick, DO, Internal Medicine, 707 Gittings Street, Suffolk VA 23434

Virginia Beach Medical Society

George R. Payne III, MD, Orthopedic Surgery, 1853 Old Donation Parkway, Virginia Beach VA 23454

Mansur Rahnema, MD, General Surgery, 1856 Colonial Medical Court, Virginia Beach VA 23454

Resident

H. J. Moore, MD, Cardiology, 3506 Timberline Trail, Roanoke VA 24018

Spinal Cord Injuries

Head Trauma

Strokes

Amputations

Multiple sclerosis

We specialize in restoring independence.

CAMC's Rehabilitation Center has everything it takes to help the seriously disabled regain physical and psychological independence.

Physical therapists. Speech and language pathologists. Psychometricians. Prosthetists. *Every* therapy discipline is represented on our rehabilitation team. Board-certified physiatrists orchestrate each patient's personalized treatment plan, supported by the only all-RN nursing staff in the state.

All treatment and technology are state-of-the-art. An independent living apartment for practicing home skills. Radiologic techniques to diagnose severe swallowing problems. A biofeedback lab to help patients manage pain and regain nerve function.

We also have one of the few adjustable ergonomic kitchens in the nation. And one of only two BTEs in the state. This Baltimore Technical Equipment enables patients to simulate many common tasks, like turning wheels and working with tools.

CAMC's Rehabilitation Center is the most comprehensive facility of its kind in West Virginia. Hospital-based, with the diversified tertiary care capabilities of CAMC as back-up.

You can refer your patients to us with confidence. And they'll return to you with confidence.

For more information and admission details, call 1-800-346-CARC.

Charleston Area Medical Center
Charleston, West Virginia

PHYSICIANS
Come Grow With Us

We are looking for physicians in:

*ORTHOPEDICS
*PEDIATRICS
*FAMILY PRACTICE
*EMERGENCY MEDICINE

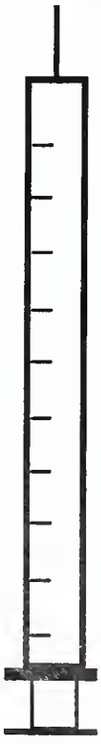
Guaranteed salary, free office space, relocation expenses and malpractice assistance await your arrival to one of the best kept secrets in the State. Direct all inquiries to James Bryan, Administrator.

JEFFERSON MEMORIAL HOSPITAL

P. O. Box 1228 Charles Town, WV 25414

(304) 725-3411 Ext. 210

60 minutes from D.C.
15 minutes from Virginia, Maryland



We take the pain out of job search!

Since 1970 we've united over 7500 physicians with medical facilities. Let our professionals serve your needs.

Recruitment
Locum Tenens
Consulting

Consolidated Physician Relocation Services
2651 Park St./Jacksonville, FL 32204
1-800-733-7999
1-904-389-7400

VIRGINIA MEDICAL CLASSIFIED

Virginia Medical classified ads accepted at the discretion of the Editor. Rates to Medical Society of Virginia members: $15 per insertion up to 50 words, 25¢ each additional word. To non-members: $30 per insertion up to 50 words, 25¢ each additional word. Deadline: 5th day of month prior to month of publication. Send to the Advertising Manager, 4205 Dover Road, Richmond VA 23221.

RICHMOND VA—BC/BE part-time/full-time Pediatrician to join established office practice in suburbs; good night/weekend coverage; salary leading to partnership; University affiliation available; excellent area to raise family, good public schools, near mountains and beach. Contact Dr. Denise Kuperminc, 804-276-5045.

PATENT SEARCHES/Biomed, Biotech or Mechanical performed by former U.S. Patent examiner, medical division, with engineering (B.S.), physiology (M.S.) and patent law experience. Reasonable rates. Contact Karen Costantino, Box 1006, MCV Station, Richmond VA 23298 or leave message 804-786-9790.

PEDIATRICIAN—Board certified or board eligible sought for busy Pediatric practice as part of multi-specialty group. Opportunities for research, patient care, teaching, excellent benefits. Send CV to Elaine Mallory, Administrative Assistant, McGuire Clinic, 7702 Parham Road, Richmond VA 23229, 804-346-1503.

FARMVILLE, Virginia—Seeking full-time and part-time physicians for hospital located 1 hour west of Richmond. Excellent compensation, full malpractice insurance coverage, and benefit package to full-time staff. Contact: Betty Albrecht, Emergency Consultants, Inc., 2240 S. Airport Road, Room 40, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

PRACTICE OPPORTUNITIES in Virginia—Excellent professional and lifestyle opportunity in southeastern Virginia. Sentara Health Plan, a staff model HMO, is seeking BE/BC Family Practice, Internal Medicine and Pediatric physicians. We are a subsidiary of Sentara Health System, the largest and most comprehensive health care network in Virginia, and are also affiliated with major teaching and community hospitals. Sentara Health Plan physicians practice at seven conveniently located Health Centers and admit patients to leading area hospitals. Outstanding cultural, educational and recreational activities. Competitive salary, benefits and incentive plan. Contact: Helen Clendenin, 22 Koger Executive Center, Suite 125, Norfolk, Virginia 23502 or call collect (804) 466-0712. An Equal Opportunity Employer.

LAB EQUIPMENT For Sale—QBC for hematology, Coagulator Unimeter 500, Unimeter 300 blood chemistry system, Lytetek System Na & K+, Riaphase Gamma Counter T_3 & T_4, Hamilton blood collecting chair. For more information call Dr. Krishna's office 804-861-8411.

BLUE RIDGE Mountains, Central Virginia—Family Practitioners (male or female) wanted to join busy small town two female/four male group practice near the beautiful Blue Ridge Mountains. Rural setting is within 30 minutes of two cities over 100,000. Hunting, fishing, boating, many large shopping centers, fine arts, theater, private schools and five colleges all within 25 miles. The University of Virginia is within 100 miles. Excellent location to raise a family. Local JCHA community hospital next door is supported by large hospital system. Prefer young, Board Certified/Board Eligible FPs to share obstetrics duties with our two FPs (one female) currently providing Obstetrics services, but will also consider non-OB track FPs. Women are encouraged to inquire. First year salary guarantee. Benefits include paid family medical, individual disability, life and malpractice insurance; paid dues/licenses, conference fees, vacation and sick leave, profit sharing. Partnership negotiable after one year. Send CV to: Wayne T. Hutchinson, MD, or Freeman W. Jenrette, MD, Physician Associates, Ltd, 1700 Whitfield Drive, Bedford VA 24523. Phone: 703-586-4723.

EMERGENCY DEPARTMENT staff physician being sought to join group of three providing coverage at client hospital located in Franklin, Virginia. Franklin is situated in historic southeast Virginia and surrounded by rolling hills and woods. Enjoy this beautiful countryside while being only 40 miles from the Norfolk/Newport News metro area and an hour and a half from the coast. This full-service facility serves a population base of 45,000. Annual ED volume 10,000. We are offering a generous rate of reimbursement plus overage arrangement, occurrence malpractice coverage, allowance for CME, professional dues and relocation expenses. For complete details, contact Cathy Long, Spectrum Emergency Care, PO Box 27352, St. Louis MO 63141; 1-800-325-3982, ext. 3015.

WINTERGREEN CONDO—Three bedroom three baths, fireplace, mountaintop with great view! Walk to Wintergarden. Easy access to tennis, golf, hiking trails. Year-round availability. Completely furnished, with microwave, cassette, stereo, dishwasher, linens furnished. Call Jay Buston, MD, 804-266-7613 or 804-272-7849.

ORTHOPAEDIC SURGERY practice for sale—Very active continuous solo practice for past 32 yrs. must discontinue due to health. Spacious fully equipped office including x-ray, space for 1-3 MDs, one block Martha Jefferson Hospital, long-term lease available. David V. Strider, MD, 404 Eighth St. NE, Charlottesville VA 22901, 804-293-6388.

APPRAISALS & SALES—The specialists in on-site practice valuations and transfers to physicians, hospitals and investors. Please contact: Ed Strogen, Fulton, Longshore & Asdsociates, Inc., 527 Plymouth Road, Suite 410, Plymouth Meeting PA 19462; 215-834-6780 or 1-800-346-8397.

FREE REPRINTS from Virginia Medical to help you in your practice: 1) Consent Forms for HIV Testing under Virginia's

IF YOU ARE CONSIDERING A purchase for a new computer, automobile, office equipment or medical equipment

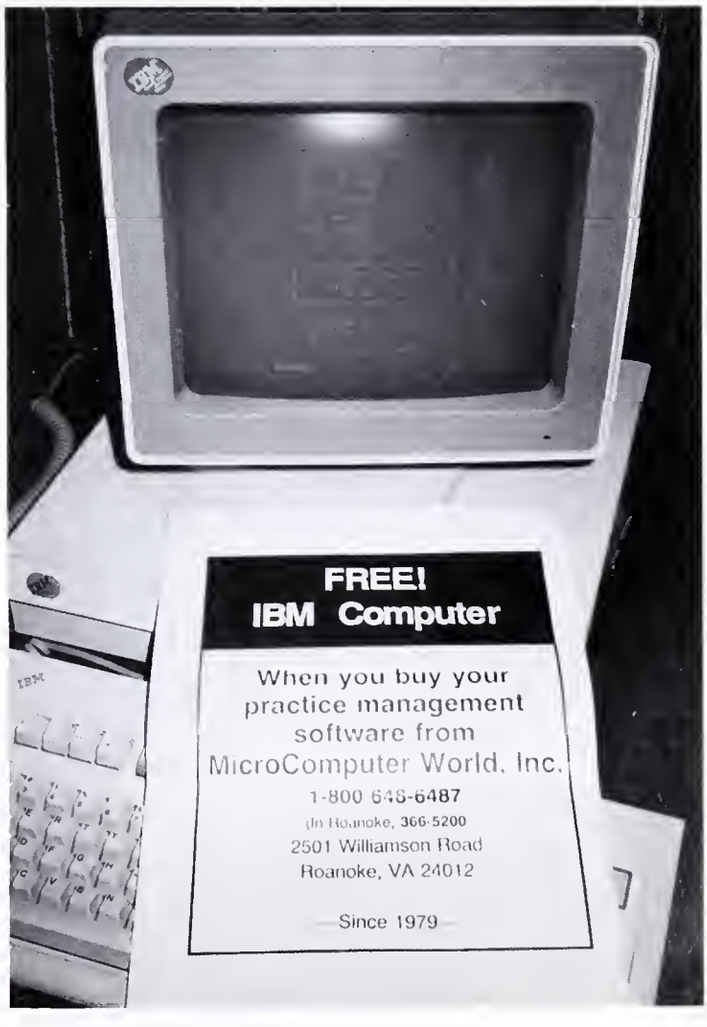
Then Let Us Lease It For You

Call
DULLES FINANCIAL CORP.

1-800-338-9913

in Northern Virginia 450-5808
313 D Cedar Lane
Sterling Va. 22170

Professional Leasing Specialists



YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85

AVAILABLE EXCLUSIVELY FROM

PALISADES PHARMACEUTICALS, INC.

219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

New AIDS Law (guidelines and sample patient forms). Va Med October 1989. 2) Physician's Guide to the Natural Death Act, with the form authorized by the 1989 General Assembly. Va Med August 1989. 3) Physician's Kit for the New Virginia High School League Physical Exam (charts, tables, and other clinical material). Va Med September 1989. Send your order to Reprints, Va Med, 4205 Dover Road, Richmond, VA 23221. Be sure to specify which reprint(s) you want.

RICHMOND, Virginia—Seeking residency-trained physicians for full-time and part-time emergency department opportunities. Two facilities with a combined patient volume of 50,000 plus provides excellent medical and surgical back-up. Double coverage provided during peak periods. Excellent compensation and paid malpractice insurance. Benefit package available for full-time physicians. For more information contact: Betty Albrecht, Emergency Consultants, Inc., 2240 S. Airport Road, Room 40, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

PHYSICIANS NEEDED, Georgia—Family Practice, Internal Medicine, Oncology, Endocrinology, Neurosurgery, Neurology, General Surgery, Orthopedic Surgery. Group practice, solo or urgent care settings available through Charter Hospital network located in Macon and serving all Middle Georgia. Your practice will be located 60 miles south of Atlanta, in growing family-oriented community, where you can avoid traffic and enjoy a rewarding professional career. Please contact Stephen Wofford at 912-741-6283 for confidential consultation or write: Charter Northside, PO Box 4627, Macon GA 31208.

HOLTER RECORDERS provided to physician's offices at no charge. Virginia Heart Institute's services includes scanning, analysis and interpretation of Holter 24-hour ambulatory recordings. Call 804-359-9265 or in Virginia 1-800-468-1030.

WINTERGREEN RENTAL—Cliffs Condominiums, two bedroom, two bath, overlooking entire Wintergreen village near top of the expert slope. Rates are substantially less than through Wintergreen's front desk. Call Thomas Shuttleworth at 804-431-3100 or write 2809 S. Lynnhaven Road, Virginia Beach VA 23452.

PRACTICE MARKETING—Customized services to increase patient satisfaction and activity. Practice analysis and profile, patient satisfaction audits, staff training, strategic planning, market demographics and referral development are among services offered to meet individual needs. Call (804) 748-7862. Market Impact, PO Box 1106, Chesterfield VA 23832.

EXECUTIVE DIRECTOR, Board of Medical Practice, State of Delaware. Coordinates all activities of Board—licensure, professional discipline, regulations, legislation, etc. MD/DO, five years current practice experience. Contact S. L. Grossman, First Resource, Inc., 7 Great Valley Parkway, Suite 110, Malvern PA 19355, 800-842-2050.

WILLIAMSBURG VA—Unusual opportunity for BC/BE Family Practitioner to take over busy practice with two other BC Family Physicians. Send CV to: Cliff Henderson, MD, Williamsburg VA 23185; or call 1-804-220-2236 or 804-229-2546.

FOR SALE/LEASE

Prime Medical Facility

3800 Meadowdale Boulevard
(Chesterfield County)

★ 7,000 SQUARE FEET, FULLY EQUIPPED, READY TO OCCUPY

★ OUTSTANDING GENERAL PRACTICE/GROUP PRACTICE FACILITY

★ GROWTH AREA OF CHESTERFIELD COUNTY

CALL: SCOTT BOYERS, SCOTT WHITE or JIM MILBY

804/788-1000 ▪ FAX 804/782-1145

Harrison & Bates
INCORPORATED

irst National Bank Building ▪ Suite 1800
23 E. Main St. ▪ Richmond, VA 23219-3308
804/788-1000 ▪ FAX 804/782-1145

NEW AMERICA NETWORK

National MULTIPLE LISTING

NOTE: This offering subject to errors, omissions, prior sale or withdrawal without notice.

NML 91623-P

"Our Concern Be Peace Of Mind."

Theocritus, 230 B.C.

Charles M. Cooper, M.D.

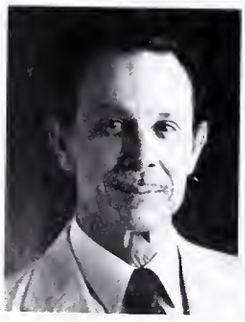
Morgan E. Scott, M.D.

Neil P. Dubner, M.D.

Arthur E. Kelley, M.D.

Basil E. Roebuck, M.D.

Don L. Weston, M.D.



Orren LeRoyce Royal, M.D.

G. Paul Hlusko, M.D.

D. Wilfred Abse, M.D.

Ronald L. Myers, M.D.

Hal G. Gillespie, M.D.

Greek poet Theocritus said it. The eleven men who comprise the Active Medical Staff of Saint Albans Hospital practice it. Every day.

They combine years of study and experience to bring patients the best available care for emotional and psychological troubles. Their special interests cover the broadest spectrum of psychiatric treatment, resulting in both adult and adolescent programs for chemical dependency, eating disorders, phobias and anxieties, and pain management.

Our doctors lead a large group of professionals and volunteers who make compassion and expert care a way of life. Saint Albans. Today and for the past 74 years we are concerned, above all, with your peace of mind.

Saint Albans Psychiatric Hospital

Radford, Virginia (703) 639-2481

VIRGINIA MEDICAL

CURRENT
JNLS
W1
VI
799J

Virginia Medical
UCSF LIBRARY
Received on: 02-23-90

The Monthly Publication of The Medical Society of Virginia

How to Comply With New Waste Regulations: Bulletin at Page 53

Medicine Abroad

I. Hospital #3 in Leningrad 59
RAY H. SMITH

II. Glasnost in Moscow, Tbilisi and Baku 60
JOHN W. HOLLOWELL

III. Nit-Picking for the Army in Rabat 62
JOHN C. WATSON

Editorials

Medical Care Here and There 75
E.L.K., JR.

The Ideal Family Physician 75
H.C. CAMPELL

Point of View

Access: Will We Nibble at the Edges or Bite the Bullet? 66
DENNIS A.J. MOREY

Medicine at Home

Eosinophilia and Myalgia Associated with L-Tryptophan Use: Case Report 68
DANIEL M. BECKER, SALEHA HABIB-HONG, AND STEPHEN M. SMITH

Abstracts for the Meeting of the Virginia Chapter, American College of Physicians, and Virginia Society of Internal Medicine ... 71

Letters to the Editor 50
JOHN F. CARY

Who's Who in Virginia Medicine 56

Obituary 76

Meetings about Medicine 78

MSV Phone Book 81

Classified Advertisements 83

Index to Advertisers 55

WIN SOUTH AMERICA TRIP FOR TWO!
DETAILS PAGE 74

When Disability Puts Your Practice on Hold...

You Can Depend on the Medical Society of Virginia Sponsored Disability Income Plan

If you became disabled, how would you obtain money to replace your lost income? How would you pay your ordinary day-to-day expenses? You can depend on the MSV sponsored Disability Income Plan to help meet your financial needs!

Highlights

- Up to **$10,000** Monthly Benefits
- Choice of a **Long Term Plan** or a **Short Term Plan**
- Choice of **4 Waiting Periods**
- Liberal definition of disability
- **Affordable** group rates

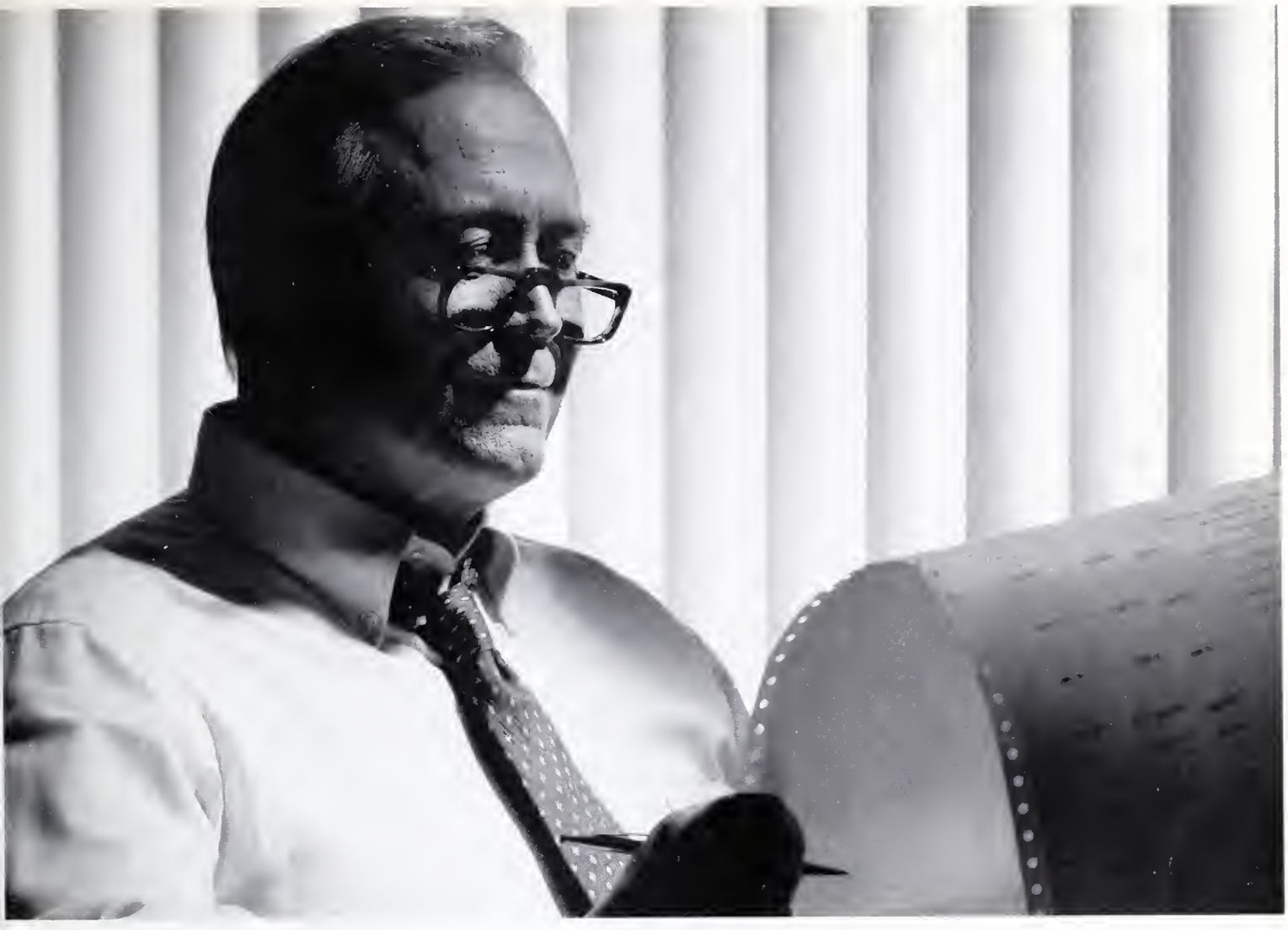
For more information about the **MSV** sponsored **Disability Income Plan**, including all costs, terms and limitations, please write the insurance administrator, John P. Pearl & Associates, Ltd., or call Toll-Free in Virginia at 800-572-2211. Local residents, call (804) 282-9600.

Administered By

John P. Pearl & Associates, Ltd.
6620 W. Broad St., Suite 300
Richmond, VA 23230-1724

Underwritten By

Life Insurance Company of North America



Three financial reasons why practices choose the ACCLAIM™ Medical System

There are many compelling reasons to automate with the ACCLAIM Medical System. Here are three important benefits our customers have taken the time to write to us about:

1 Improved Cash Flow

"We have seen dramatic improvements in the efficiency of filing insurance claims and tracking accounts. We've also seen substantial improvement in our accounts receivable."

Susan Shaffer, Office Manager
Single Physician Practice

2 Increased Productivity

"The system is easy to use, straightforward in its commands and simplifies medical office management beyond belief."

Judy Greenburg, Office Manager
Four Physician Practice

3 Financial Control

"Sentient's ACCLAIM system has improved our collections by 100% and has provided reliable data on which to base practice management decisions."

Frank J. Mayo, M.D., Pulmonologist

Sentient Systems offers total solutions. Hardware (IBM® and compatible), software, installation, data conversion, training, support and service are a part of every system. We provide the highest quality medical system available today. Just ask our customers.

For a free consultation call Sentient at:

301-929-7600
800-247-9419

ACCLAIM is a trademark of Sentient Systems, Inc.
IBM is a registered trademark of International Business Machines Corporation.

I'm interested. Please...

☐ Rush me an information portfolio.
☐ Call to set up a free office analysis.

I plan to purchase within:

1 month ___ 2 months ___ 3-6 months ___

Practice Name

Address

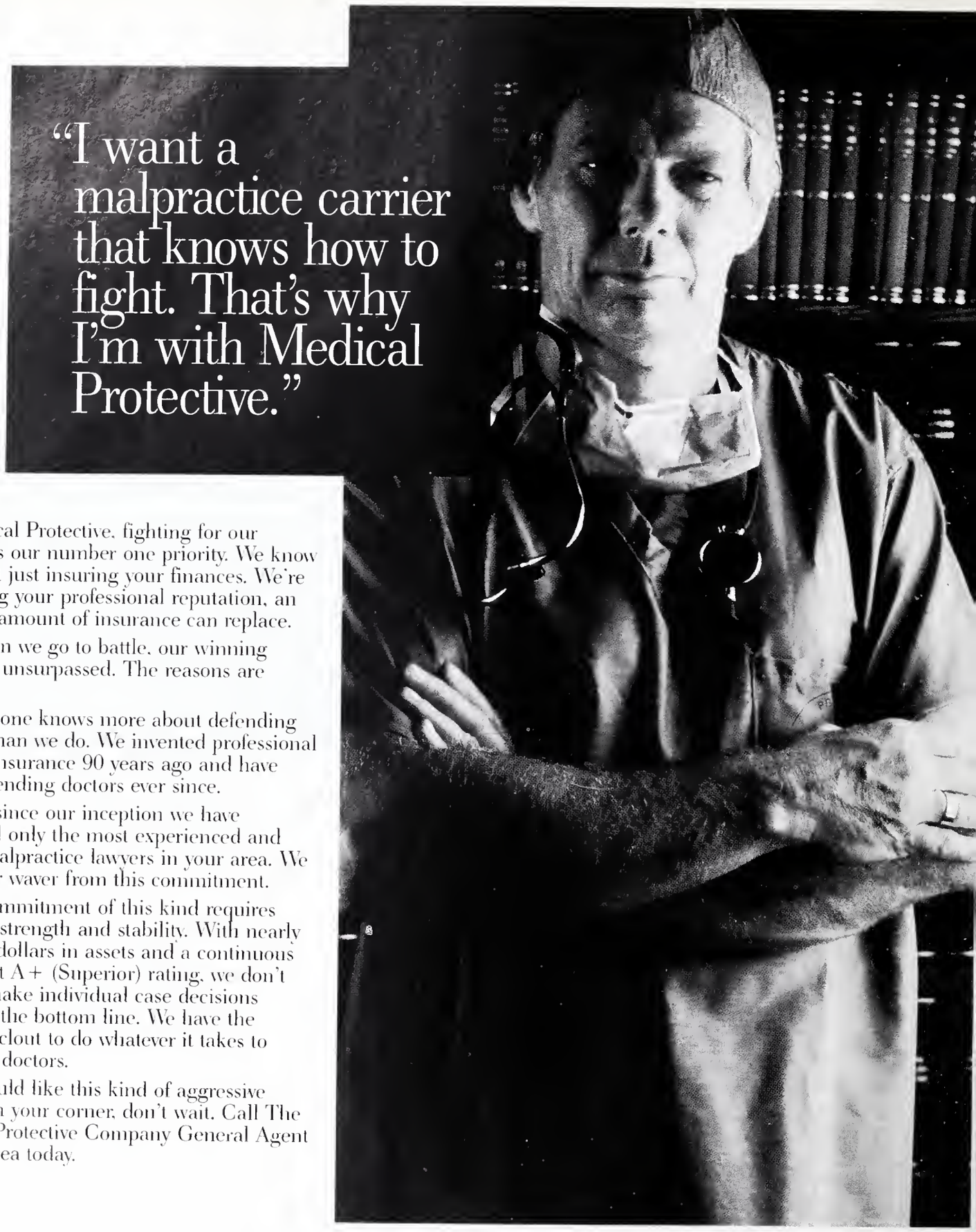
City State Zip

Telephone Best time to call

Return to: Sentient Systems
10410 North Kensington Parkway
Kensington, MD 20895-2939

SENTIENT
SYSTEMS

THE MEDICAL COMPUTING LEADER



At Medical Protective, fighting for our doctors is our number one priority. We know we're not just insuring your finances. We're protecting your professional reputation, an asset no amount of insurance can replace.

And when we go to battle, our winning record is unsurpassed. The reasons are simple.

First, no one knows more about defending doctors than we do. We invented professional liability insurance 90 years ago and have been defending doctors ever since.

Second, since our inception we have employed only the most experienced and skilled malpractice lawyers in your area. We will never waver from this commitment.

Third, commitment of this kind requires financial strength and stability. With nearly a billion dollars in assets and a continuous A.M. Best A+ (Superior) rating, we don't have to make individual case decisions based on the bottom line. We have the financial clout to do whatever it takes to serve our doctors.

If you would like this kind of aggressive defense in your corner, don't wait. Call The Medical Protective Company General Agent in your area today.

THE
MEDICAL PROTECTIVE COMPANY

America's premier professional liability insurer.

Ted J. Pandak, David R. Fuller, Suite 205, 7275 Glen Forest Drive, Richmond, Virginia 23226, (804) 285-4131

FreeVideo!

To help you automate your practice.

If you are considering automating your practice within the next 12 months, I will send you a free video tape, which will enable you to learn the major factors contributing to the success or failure of a computer system in a medical practice. This tape gives you the opportunity to draw on the experience of other practices that have successfully automated. And you can do this in the comfort of your home or office with a minimal time investment.

Mr. Ami Elis
President
Elcomp Systems, Inc.

FLEXIBLE™ PACKAGE

by ELCOMP®
Elcomp Systems, Inc.

Foster Plaza VI, 681 Andersen Drive, Pittsburgh, PA 15220
1-800-441-8386

IBM Business Partner
Authorized Industry Remarketer

☑ **Yes, please send me your free video.**

Practice name _____

Address _____

City, State, Zip _____

Phone _____

Specialty _____

Number of Physicians _____

LETTERS

Taking up the cudgels: cigarettes, cancer and car keys

I feel that the recently published letter of Dr. Stuart Ragland, Jr.,[1] should not go unanswered. He stretches the rules of logic and science to show that the evidence that cigarettes cause lung cancer and other illness is "merely" statistical and that we risk making a "mockery of the profession" for promoting such ideas without rigorous scientific data. This is utter nonsense.

In the first place, even if we had only epidemiological data, those data are very strong. Combining many studies, hundreds of thousands of patients have been followed and a consistent relationship is found between cigarette smoking and lung cancer. Furthermore, the risk increases with the number of years of smoking, number of cigarettes smoked daily, amount of inhalation, and presence of other known carcinogens. The main risk factor for lung cancer in asbestos-exposed workers is not the degree of asbestos exposure but a history of cigarette smoking. The risk of cancer drops in quitters and is higher than normal in "passive smokers." These *facts* are hardly "more wrapped in emotion than scientific truth."

In the second place, the only data are *not* epidemiological. Cigarette smoke contains many chemicals which are mutagenic or carcinogenic in bacterial or animal models. Animals forced to inhale cigarette smoke develop lung cancer (although, as in humans, not at a rate of 100%). The fact that not everyone who smokes develops cancer does *not* prove that smoking does not cause cancer. My car doesn't start every time I turn the key. On the other hand, some persons can start a car *without* a key. Do you think for one minute my kid is going to tell me, "But Dad, I didn't start the car; I just turned the key, and we both know that that's not what really makes the car start"? Let's show some common sense here! Volumes of data point to the obvious fact that smoking is one possible step in a complicated path to generating a cancer.

In the third place, he confuses "genetic" with "hereditary" etiologies. (Incidentally, the chromosomal changes he describes are "only statistically associated" with lung cancer and generally have been identified only *after* the cancer has been diagnosed, frequently after the patient has received mutagenic anticancer chemotherapy.) It is possible or even likely that these changes may not be hereditary but induced by carcinogens, e.g., in cigarette smoke.

DO NEW MEDICAL MALPRACTICE CARRIERS MAKE YOU NERVOUS?

Some medical malpractice carriers offer a low price the first couple of years. After that, who knows?

We've been independent brokers for more than forty years and can offer competitive policies and premiums. We're not limited to an endorsed policy or exclusives required by many insurance carriers.

Find out about some **"A+"** companies who have established a track record. Save yourself some money.

We can advise you on the *best* policy for all your needs—from the *best* company at the *best* price. Frankly, we can handle all your professional and personal insurance needs, from office packages to auto coverages.

Call Clements and Company today for an "independent's approach" to buying medical malpractice insurance.

INSURANCE BROKERS WORLDWIDE

CLEMENTS AND COMPANY

Specialist in Medical Malpractice Insurance

Telephone: (202)872-0060 **Fax:** (202)466-9064

Telex: 64514 **Cable:** CLEMENTS/WASHINGTON

1730 K Street, NW, Suite 701, Washington, DC 20006

In the fourth place, he seems to think that basic research is more important than prevention. Would he have us abandon sanitary water systems now that we can cure dysentery? Stop isolating TB patients now that there is effective chemotherapy? Not obey traffic signals now that we have an efficient trauma system in our state? Why then would he have us continue smoking when there isn't even a cure for the cancer it causes?

To answer his concluding quote with another, I would paraphrase Rene DesCartes, who stated that we should certainly keep an open mind on the issue, but not so open that our brains fall out.

John F. Cary, MD

9590 Surveyor Court
Manassas VA 22110

1. Ragland SRjr. The subject of smoking: more emotion than scientific truth? Va Med 1989;116:451-2

Dr.Ragland replies: Nothing is "silly" about dispassionate scientific enquiry nor is ridicule an acceptable part of a truthful search. Epidemiological studies provide paths that may lead to biological truths. Statistics allow for probabilities. Neither elucidate the mechanisms of disease. They are but adumbrations of basic scientific phenomena. No comment on car keys.

CLINICAL RESEARCH ANGINA

☐ 8-Week Serial Exercise Testing

☐ Isosorbide-Mononitrate
(Beta-Blocker May Be Continued)

☐ Cardiac Catheterization Costs Covered,
If Procedure Deemed Necessary

☐ Primary Care Physician Services Covered

VIRGINIA HEART INSTITUTE
205 North Hamilton Street
Richmond, Virginia 23221

804-359-9265

CHARLES L. BAIRD, JR., M.D.,
Investigator

VIRGINIA MEDICAL

Journal of The Medical Society of Virginia
4205 Dover Road, Richmond VA 23221
(804) 353-2721

Editor
Edwin L. Kendig, Jr., MD, Richmond

Associate Editors
Richard G. Lester, MD, Norfolk
Duncan S. Owen, Jr., MD, Richmond
John A. Owen, Jr., MD, Charlottesville

Editorial Board
H. C. Alexander III, MD, Roanoke
Raymond S. Brown, MD, Gloucester
Henry S. Campell, MD, Martinsville
C. Barrie Cook, MD, Fairfax
Eloise C. Haun, MD, Woodstock
Walter Lawrence, Jr., MD, Richmond
Lockhart B. McGuire, MD, Charlottesville
Robert Edgar Mitchell, Jr., MD, Richmond

Executive Editor
Ann Gray

Business Manager
James L. Moore, Jr.

Virginia Medical (ISSN 0146-3616) is the monthly publication of The Medical Society of Virginia. Second-class postage paid at Richmond, Virginia. Yearly subscription rate: $24 domestic, $30 foreign; single copies, $3. Virginia Medical does not hold itself responsible for statements made by any contributor. Although all advertising is expected to conform to ethical medical standards, acceptance does not imply endorsement by this journal, and the publisher reserves the right to reject any advertisement. POSTMASTER: Send address changes to Virginia Medical, 4205 Dover Road, Richmond VA 23221. DISCLAIMER: Advertisements in Virginia Medical for products, services, courses and symposia are published with a "buyer beware" understanding. The Publisher, the Editor and members of the Editorial Board do not imply warranty of products, nor endorsement of offered educational material.

If your mailing address is to change, notify the Executive Editor at the earliest opportunity. Send both your new address and an old mailing label.

PUT YOUR MEDICAL CAREER IN FLIGHT.

Discover the thrill of flying, the end of office overhead and the enjoyment of a general practice as an Air Force flight surgeon. Talk to an Air Force medical program manager about the tremendous benefits of being an Air Force medical officer:

- Quality lifestyle, quality practice
- 30 days vacation with pay per year
- Support of skilled professionals
- Non-contributing retirement plan if qualified

Discover how to take flight as an Air Force flight surgeon. Talk to the Air Force medical team today. Call

USAF HEALTH PROFESSIONS

STATION-TO-STATION COLLECT 804-276-0459

AIR FORCE

MORE THAN **250,000** PATIENTS HAVE ENJOYED HEALTH BENEFITS RESULTING FROM MEDIFAST.

MORE THAN **10,000** PHYSICIANS PRESCRIBE MEDIFAST WITH CONFIDENCE.

MORE THAN **10** YEARS OF DEDICATED SERVICE TO THE MEDICAL PROFESSION.

No Other Physician-Supervised Weight Control Program Delivers This Winning Combination ...and that makes Medifast #1

Physician-Supervised Protein-Sparing Modified Fast For the Safe • Rapid • Medical Treatment of Obesity

Doctor, one of every four of your patients has overweight problems that need medical help...the help of Medifast®.

A comprehensive program for rapid weight loss *and lifelong weight control,* Medifast has proven itself. For more than 10 years! To more than 10,000 physicians! To more than 250,000 patients!

TRAINING MANUALS

Medifast will work for you, too. Patients lose weight with a program of physician-supervised modified fasting and behavior modification. And they keep it off with our exclusive *LifeStyles* Program.

The Medifast Program includes:

★*Training* – Comprehensive training manuals written by physicians, for physicians. Address all clinical and administrative aspects.

★*Medifast Supplements* – Extremely high quality. Medically formulated. Nutritionally complete.

★*LifeStyles* – The Medifast Program of Patient Support™. Teaches patients the way to long-term weight control and healthful living.

★*Clinical Consultation* – Medical and technical support specialists available daily at our toll-free number.

★*Practice Promotion Portfolio* – Complete with marketing ideas, office displays, posters, waiting room brochures, and advertising.

★*National Consumer Ad Campaign* – Builds public awareness, creates referrals.

LifeStyles; PATIENT SUPPORT

You know, Doctor, that more traditional methods of weight reduction are simply ineffective. And, severe overweight threatens your patient's health. Primary Care Physicians of every specialty recognize Medifast to be an important addition to their prescribed therapy and an effective way to increase their patient base.

PROMOTION PORTFOLIO

For complete information call toll-free

1-800-638-7867

For more information about the Medifast Program, please send this coupon to:

The Nutrition Institute of Maryland
William J. Vitale, M.D.
Director, Clinical Services
1840 York Road, Suite H
Timonium, MD 21093

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ SJG-12

MEDIFAST

The Physicians' Answer to Weight Control.

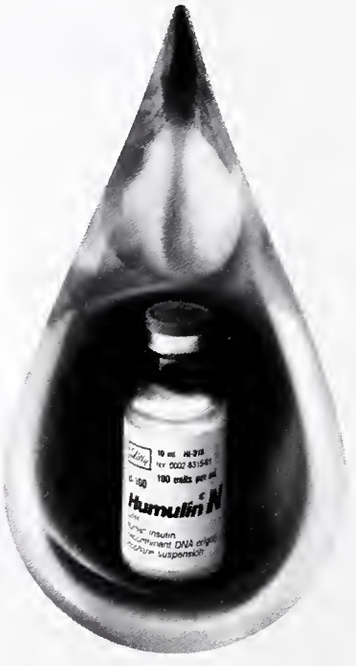
©Jason Pharmaceuticals 1989

For treatment of diabetes:

Introducing
Humulin® 70/30
70% human insulin isophane suspension
30% human insulin injection
(recombinant DNA origin)

REPLACE
Human Insulin

With Human Insulin



Humulin®
human insulin
(recombinant DNA origin)

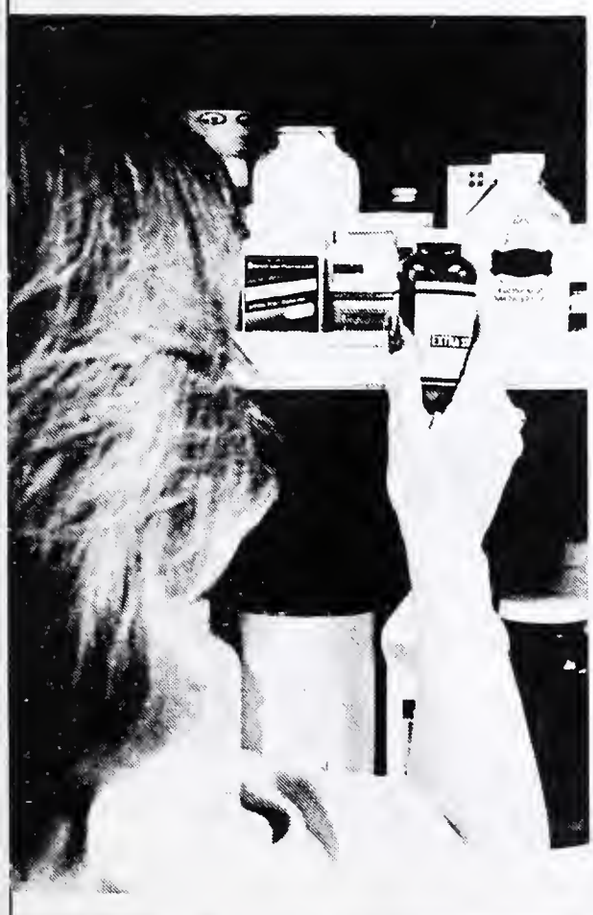
Any change of insulin should be made cautiously and only under medical supervision.

Lilly Leadership In Diabetes Care

© 1989, ELI LILLY AND COMPANY HI-2914-B 949334

DIRECTORY OF ADVERTISERS

Central Fidelity Bank Gold Mastercard Program 81
Clements & Company 50
Elcomp Systems, Inc.....49
Harrison & Bates, Inc. 82
Health of Virginia.....70
Jason Pharmaceuticals, Medifast Division 53
Jefferson Memorial Hospital 84
Eli Lilly & Co. 54
Medical Protective Company 48
Merck, Sharp & Dohme.....Covs 3, 4
Micro Computer World, Inc. 55
Palisades Pharmaceuticals 83
John P. Pearl & Associates .....Cov 2
Peoples Drug Stores.....57
Reed and Carnrick.....79
Richmond Headache Center 55
Roche Laboratories.....58
Sentient Systems, Inc. 47
Sheppard Pratt 77
United States Air Force 52
United States Army 80
Virginia Heart Institute 51
Virginia Insurance Reciprocal.....64-65



HEADACHE

THERE IS AN ALTERNATIVE

Headache is the most common disorder of modern man. It has been estimated that one out of three Americans suffers from severe headaches at one time or another.

The RICHMOND HEADACHE CENTER is a unique facility which specializes in the diagnosis and management of chronic and recurrent headaches.

The RICHMOND HEADACHE CENTER was founded by a group of practicing neurologists and clinical psychologists who recognized the need for a cooperative effort in treating chronic and recurrent headaches.

For more information, write or call .....

YES, please send me more information about RICHMOND HEADACHE CENTER.

NAME

ADDRESS

STATE

ZIP CODE PHONE

MAIL TO: RICHMOND HEADACHE CENTER
909 Hioaks Road, Suite 1
Richmond, Virginia 23225

RICHMOND HEADACHE CENTER
909 Hioaks Road, Suite I
Richmond, Virginia 23225
Telephone (804) 320-3750

WHO'S WHO

Two pathologists associated in the management of American Medical Laboratories in Fairfax City, Virginia, have been elected to leadership posts by specialty society peers. They are **Dr. C. Barrie Cook,** who was named president elect of the American Society of Clinical Pathology at its annual meeting in Washington DC, and **Dr. Ira D. Godwin,** who was installed as president of the American College of Nuclear Medicine during its meeting in Chicago. The two men have been associated since 1961, two years after Dr. Cook founded American Medical Laboratories; Dr. Cook is now chairman of the board, Dr. Godwin is president and chief executive officer. Their firm employs nearly 900 persons, making it one of the largest private employers in the Washington metropolitan area. Both men have contributed dynamically to the Medical Society of Virginia. Dr. Cook, a Past President of the Society and winner of its Community Service Award, is currently an MSV delegate to the AMA. Dr. Godwin sits on the Society's Council as the councilor from the 10th District and currently heads up two MSV Committees, Insurance and Professional Liability Review.

Dr. William D. Sasser, Fredericksburg, is the new president of the Virginia Vascular Society. He was elected at the Society's annual meeting in Williamsburg.

New president of the Virginia Society for Pathology is **Dr. Benjamin C. Sturgill,** Charlottesville, who was elected at the Society's annual meeting in December.

New president of the Association of Life Insurance Medical Directors of America is **Dr. Lawrence D. Jones** of Lynchburg, where he is vice president and medical director of First Colony Life Insurance Company. Founded in 1889, the Association he heads has a world-wide membership.

To the November 1989 issue's list of three newly elected fellows of the American College of Radiology must be added these two whose names were inadvertently omitted: **Dr. William Bruce Lundeen,** Arlington, and **Dr. Brian R. J. Williamson,** Charlottesville.

Dr. Lawrence C. Varner, Farmville, has been named a fellow of the American Academy of Family Physicians.

Dr. Richard P. Keeling, director of the University of Virginia's Department of Student Health, was one of 11 physicians and dentists from over the country honored recently for their care of people with AIDS. The awards were presented by the US Public Health Service. Dr. Keeling, president of the American College Health Association and chairman of the board of the National AIDS Network, was cited for "selfless dedication, compassionate service and outstanding leadership in providing medical care to people with HIV infection and AIDS."

A Norfolk obstetrician/gynecologist who dropped his practice in 1984 and is now "totally addicted to painting" was the winner of the 1989 Urbanna Oyster Festival artwork competition. He is **Dr. William N. Reingold,** whose realistic portrayal of "York River Oystermen" took the prize. Dr. Reingold has won several prizes at shows in the Tidewater area, including the Portsmouth Seawall Show and the Hampton Roads Medley of the Arts. He is represented in Norfolk by Harbour Gallery and in Virginia Beach by Gallery 32. "I'm the luckiest man in the world," he told a reporter for Urbanna's *Southside Sentinel*, explaining that after 31 satisfying years an an ob/gyn, he has now fulfilled a lifelong ambition to paint full time. "How many other people get two shots at it?" he asked rhetorically. "I don't take it for granted." He is self-taught, paints from photographs, uses acrylic paints, and specializes in scenes on and around the water. His Oyster Festival winner was printed on the cover of the Festival's program and its official T-shirts.

Dr. John A. Jane, Charlottesville, has been elected to a six-year term as a director of the American Board of Neurological Surgery. Dr. Jane has been professor and chairman of neurosurgery at the University of Virginia since 1969.

A geriatrics chair in the Department of Internal Medicine at Eastern Virginia Medical School has been endowed with a $1 million gift, and it will carry the name of **Professor John Franklin, MD,** who has been a strong supporter of the Norfolk school since its inception and is now director of the EVMS geriatrics program. A graduate of the Yale School of Medicine, Dr. Franklin came to geriatrics by way of internal medicine and cardiology.

Five Medical Society of Virginia members were appointed recently to endowed professorships at the Medical College of Virginia/VCU. They are **Dr. W. Robert Irby,** Charles W. Thomas Distinguished Professor of Rheumatology; **Dr. Austin I. Mehrhof,** Leroy Smith Distinguished Professor of Plastic Surgery; **Dr. Duncan S. Owen, Jr.,** Taliaferro-Scott Distinguished Professor of Internal Medicine; **Dr. John D. Ward,** Harold I. Nemuth Professor of Neurosurgery; and **Dr. Harold F. Young,** Edward and Elizabeth Hirschler Distinguished Professor of Neurosurgery. The appointments brought to 16 the number of MCV faculty endowments.

Think of it as a health care library for your patients.

We know every one of your patients is unique. With different needs. . . different treatments. And very different questions about their health care needs.

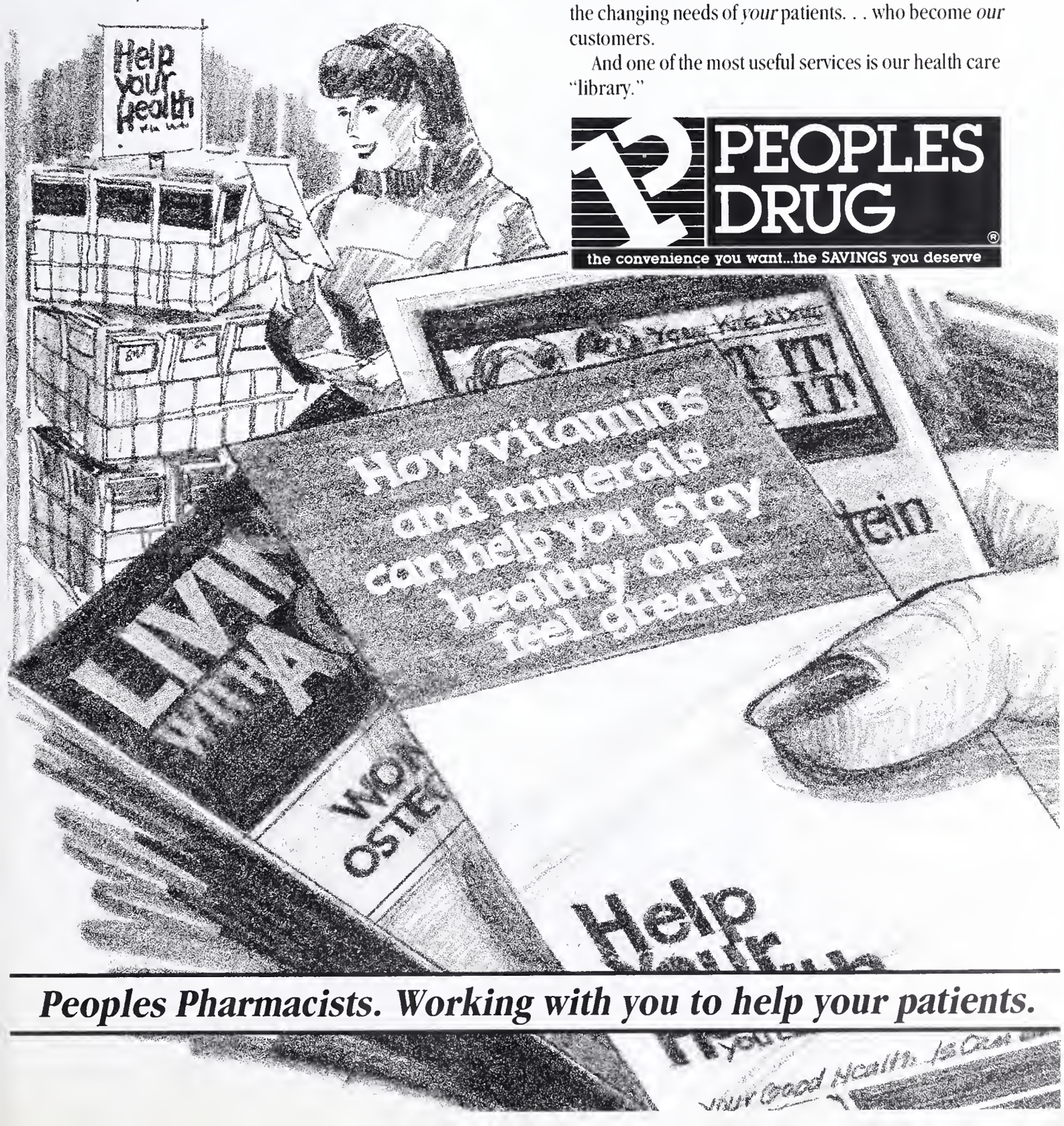
So we publish a broad spectrum of health care pamphlets to meet the informational needs of your patients. They're all free and your patients can pick them up at the pharmacy counter of any Peoples Drug Store. They include series such as "Your Kids & Drugs—Spot It—Stop It," "Living With Aging," and "Help Your Health—You Can, We Can." Plus individual pamphlets on Rabies, Poison, Insect Stings, Immunization, and many more topics.

It's just another example of how—for over 80 years—Peoples Drug has served its customers with unmatched care and professionalism. Today, all our services reflect our continuing commitment to meeting the changing needs of *your* patients. . . who become *our* customers.

And one of the most useful services is our health care "library."

PEOPLES DRUG®

the convenience you want...the SAVINGS you deserve



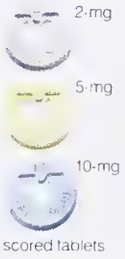
Peoples Pharmacists. Working with you to help your patients.

The practice is yours.
The patients are yours.
The prescriptions are yours.

Make the prescribing decision yours, too.

Sign on the right on
the "Dispense as written" line.

Specify VALIUM® brand of diazepam/Roche® (IV)



The cut out "V" design is a registered trademark of Roche Products Inc

The one you know best.

Copyright © 1988 by Roche Products Inc.
All rights reserved

ROCHE Roche Products

Roche Products Inc
Manati, Puerto Rico 00701

VIRGINIA
MEDICAL
FEBRUARY 1990

Medicine Abroad: I. Hospital #3 in Leningrad

By Ray H. Smith, MD, Richmond, Virginia

I HAVE just returned from a tour and medical seminar in the Soviet Union sponsored by the Medical Society of Virginia and other medical societies in the United States. While in Leningrad, I had the opportunity of visiting Hospital #3 with a group of American physicians and here report on that experience.

This hospital was selected for us by Intourist, the national Russian tourist agency which determines what tourists may see throughout the U.S.S.R. Since this particular hospital was chosen, it was our feeling that it was probably one of their better hospitals.

We had a courteous reception at the hospital and a friendly interview through an interpreter with a Russian physician who was the assistant chief physician and "Director of Treatment" of the hospital. We had an informative question and answer session with the physician, and the following consists of what we were told, plus my own observations.

Hospital #3 is a 1200-bed, acute-care, general hospital without obstetric or pediatric services. The hospital is a large, U-shaped, plain, brick building, probably six or eight stories tall, and appeared to occupy four or five acres. It was built seven years ago and is already in poor repair, with broken windows, cracking plaster and in need of painting. There is one small parking lot, which is all that is necessary since very few Russians own cars. A hospital ambulance in the parking lot contained a canvas stretcher of World War II vintage and what appeared to be a first aid box, but no oxygen or other equipment or supplies were evident.

The hospital serves a residential area in Leningrad of one million people. About 5% of admissions are referred from clinics and 95% are admitted as emergencies. We did not determine the average daily census but were told that the overall average length of stay is about three weeks. The average length of stay for an acute myocardial infarction is three to four weeks and for an appendectomy and herniorrhaphy, about two weeks. We were also told that the length of stay is similar in hospitals throughout the Soviet Union and that there is no governmental pressure to reduce the length of stay.

The doctor told us that the hospital has a large trauma and active neurosurgical service, but they do not have a CT scanner. Arteriograms also apparently are not done at this hospital. Patients in need of such studies are transferred to another hospital, but it was unclear as to the number and what type of patients are actually transferred.

Pulmonary disease apparently is very common, which is not surprising since most Russians seem to smoke, and the doctor was especially proud of a new arterial blood gas machine. He also was very excited about the recent acquisition of a SMAC machine for blood chemistries, and took great pleasure in showing it to us, although it was not yet in operation.

From what we could observe in an incredibly small laboratory for this size hospital, all laboratory studies were being done manually.

At our request, we were shown the "coronary care unit," which consisted of two rooms, each with four old metal beds, with adequate open space between the two rooms. One room was for males and the other for females. There were no curtains or screens between the beds, and monitors above the beds were not working. The central monitor placed between the two rooms was turned off and when turned on for us,

Dr. Smith is a specialist in cardiovascular diseases. Address correspondence to him at 909 Hioaks Road, Richmond, VA 23225.

revealed three monitor strips for eight patients. Two of the strips revealed only straight lines and the other revealed marked 60-cycle interference, making any kind of interpretation impossible. No patient had an IV, and nasal oxygen was administered through a large, red rubber tube. No defibrillator was evident, and hemodynamic monitoring was obviously impossible in this unit. When asked about thrombolytic therapy for an acute myocardial infarction, the doctor did not understand the question. We were told that patients who needed cardiac catheterization or cardiac surgery were transferred to another hospital. We were also told that coronary artery angioplasties were being done in some hospitals but obviously not this one.

On another occasion, we visited a "Preventive Medicine and Disease Prophylactic Center" for automobile workers, which demonstrated a pretty good picture of medieval medicine being practiced in the late 20th century!

It would appear that medicine in the U.S.S.R. is ten to twenty years behind the U.S., if what we observed is representative of medicine as practiced there.

I would encourage anyone who has the chance to visit the Soviet Union (depending on the political situation), for an unforgettable experience, to see first hand that the Communist system does not work for the benefit of the people and to have a much better appreciation of our country and government despite our problems. I would also advise anyone traveling in Russia not to get sick.

II. Glasnost in Moscow, Tbilisi, Baku

By John W. Hollowell, MD, Portsmouth, Virginia

In the summer of 1989 I joined a party of 20 American urologists and guests on a two-week tour of Russian medical facilities. The trip was led by Dr. Jay V. Gillenwater, professor and chairman, Department of Urology, University of Virginia. Three of the 15 Soviet republics were visited: Russia, Georgia and Azerbaijan. Visits to medical facilities in these countries were prearranged by Prof. Nicolai Lopatkin, director of the Moscow Urological Research Institute, and his English-speaking associate, Dr. Anatoly Darenkov. An Intourist escort assigned by the Soviet government stayed with the party throughout the trip and was joined at each city visited by a local Intourist guide.

We went first to Moscow, where we stayed at the 30-story Cosmos Hotel, an impressive edifice of several thousand guest rooms. Assignment to room was by coupon issued at the registration desk. This was handed to the "key girl" on each floor in exchange for the room key. The process was reversed on leaving the room each and every time. The constant monitoring provided good security and might well be emulated by American hotels.

Next morning Professor Lopatkin proudly escorted the group through his research laboratory and a portion of the 300-bed Institute. He was reputed to be of high position in the Communist Party, and his station apparently carries many perquisites, among them frequent trips abroad and a good deal of sophisticated equipment. The building was described as ten years old but looked much older and was of poor construction and finish. The main stairway was a showpiece, with Oriental carpeting over marble steps, but the host laughingly explained that it was built for show and rarely used.

Some mention was made of an organ transplant program, and a busy dialysis unit was visited. The patients were in wards, and sterility precautions were sparse. Catheters draining through dirty rubber tubes into open containers on the floor reflected practices abandoned in this country over 40 years ago. A lithotripter unit (ESWL) was functioning, and the equipment appeared to be a Russian copy of the original West German machine. Dr. Lopatkin answered questions freely, stating that Russian medicine was not up to American standards, pointing out that "the Soviet Union is only 72 years old and the United States has over 200 years of experience. Give us time."

The next day we made the 1200-mile flight to Tbilisi, capital of the Republic of Georgia and birthplace of Stalin. The semi-tropical, fun-loving atmosphere of Georgia was in marked contrast to Russia. With no notice or explanation (standard practice), Intourist changed our reservations from a modern hotel on the edge of town to the downtown Hotel Tbilisi, an aged but elegant building predating the Revolution. There was no air conditioning, but high ceilings helped relieve the oppressive heat.

Across the street was a blood-stained sidewalk, fronting a government building, where two months earlier 19 students had been slain in a "freedom uprising." At night, students still milled about the

Dr. Hollowell is in the private practice of urology at 226 Fort Lane at Crawford Parkway, Portsmouth VA 23704.

Corner of typical patients' ward in a 1500-bed general hospital in Leningrad. The patient was being treated for an intestinal obstruction. Her surgeon stands at right in the tall hat that is part of the white uniform worn by all physicians in the hospital. *Photograph by the author.*

streets, providing an air of tension, and a loud crash of broken glass that awakened everyone one night proved to come from a champagne bottle hurled through a window by a protesting youth.

In Tbilisi the group had a two-hour visit with Prof. Lauri Managadze, director of the Urological and Nephrological Institute of the Georgian SSR, one of three such institutions in the Soviet Union. He apologized for not inviting us to the Institute but explained that major repairs were being done. Professor Managadze was very open and candid and admitted to a lack of such medical amenities as scans, ultrasound, ESWL. He confirmed information obtained in Moscow that vasectomies are illegal in Soviet countries; abortions, however, are free and anonymous, and the average Soviet woman has eight to ten abortions in a lifetime. The vasectomy ban stems from the government's desire to increase the population above the current 284 million mark (for all 15 republics).

Professor Managadze was asked about the effects to date of perestroika. He was enthusiastic, listing: 1) more openness, democracy; 2) can now send his staff doctors to foreign lands for study without Moscow approval; 3) can now order equipment, such as CT scanners and ESWL, at the republic level without Moscow approval. In other words, decentralization of power has occurred.

From Tbilisi we flew to Baku, capital of Azerbaijan, an Asian country with a strong Muslim influence. Baku is an old city on the Caspian Sea, from whence comes 85% of the world's black caviar. A visit to a urology clinic in Baku was surprising: It had good equipment and was well-staffed, possibly because of its location in an oil-rich, busy, trade city.

A four-hour flight from Baku delivered the tour group to Leningrad, where we stayed at the Hotel Pribaltiyskaya on the Bay of Finland and visited a general hospital of 1,500 beds, 75 of them reserved for urology patients. Medical care in this hospital appeared to be 40-50 years behind the United States. The physical plant was dreary and poor, the equipment antiquated.

Here are some observations on Soviet health care I brought home with me.

Approximately 70% of Soviet doctors are women, and the percentage used to be larger. Doctors abound in the Soviet system—double the number per population compared with the States. The training is poor. One is required after finishing high school to decide whether to go into academics and what specialty to pursue. Medical school requires six years and is geared to specialization from the start. A lack of residency programs means poor preparation for practice. One female radiologist said her specialty training was limited to six weeks.

There is difficulty getting doctors to serve in rural areas and special incentives are offered. A *feldsher* system abounds. The *feldsher* corresponds to the German "field Barber" and has training comparable to that of a Navy corpsman, or perhaps a midwife. Much rural care is practiced by these paramedics. The government tried to abandon this system in the 1930s but it proved too popular and firmly ingrained to change.

There is a tiered medical system with high party officials receiving good medical care and the common

people getting poor care. The KGB, members of the Academy of Sciences, and Communist Party elite have their own autonomous health systems. Bribes, evident in all of Soviet life, abound for better health services and special care. Unlike England, the Soviet health system has no private or philanthropic enterprise competing with the socialist system.

Only about 3% of the "net material product" of the Soviet Union is dedicated to health care, compared with 12% of the comparable gross national product in the United States. Physician compensation is poor, 250-350 rubles per month. (At the exchange rate then of one ruble = $1.60, this translated to $400-$560,—but early in November I read that the official rate had changed to $.16 per ruble, one-tenth as much! This reflects the economic chaos of the Soviet Union.) If a physician has a high position in the Party, he/she might receive 500 rubles per month. The chief of surgery in the Leningrad hospital stated he had three incomes but still could not afford a car. His apartment and clothing are modest. His food is adequate; rarely can he afford to dine out. The nursing profession is held in low esteem and therefore attracts few. Nurses train for two years and are paid 90 rubles per month.

Supervision of health care in the Soviet Union is the responsibility of the Union Minister of Health, who presides over a hierarchy of nearly 6,000 subordinate ministries and health departments in the 15 republics. Much health care is centered around the workplace, with factories building their own hospitals, but they, too, are under the Minister of Health. Again, in this self-described egalitarian society the elite enjoy unusual privilege.

Communist Party aside, one is impressed with the friendliness and sincerity of the people of the Soviet Union. There is a sense of beauty in these people, who through the ages have become tolerant of war and adversity, who accept a life of grief. The United States would do well to continue in its policy of building bridges to friendship and peace.

III. Nit-Picking for the Army in Rabat

By John C. Watson, MD, Alexandria, Virginia

RECENTLY I've been hearing travel advertisements for French Morocco on radio and television. They make me nostalgic for my youth and for Rabat, the capital of Morocco, where the Army sent me in 1943 during World War II. I was in the 45th General Hospital, the Medical College of Virginia unit out of Richmond, technically geared for 1,800 patients. In actual practice overseas, more than one-half of these patients were in tents convalescing.

We sat at Camp Lee for almost nine months, then went overseas immediately after the North African invasion, landed at Casablanca, thence to Rabat, the capital of Morocco. Most of us suffered from the total geographic ignorance common to Americans at that time. We expected lions to jump out of the bushes and found instead a charming French Moroccan capital. The French section surrounded the native section, which was called the Medina, the word meaning "fort." This was a walled-in city with narrow streets and open sewages. Its bazaar had the traditional streets of leather goods, streets of meat, streets of copper, etc., and one U-shaped street, which was the traditional street of prostitution. The Medina, which had typhus, smallpox, and venereal diseases you wouldn't believe, was technically off limits; but the troops returning, mostly from the Kasserine Pass, which was the disastrous Bull Run of this North African war, paid no attention to the "Off Limits" signs and would follow any native woman into the Medina. The women wore djellabas and held their hoods across their faces; I never saw a veil and it was impossible to tell what color they were unless you looked at their heels in the open-heeled babouches they wore. We were the only medical installation in that area.

The Allied Commander of Rabat was a former lieutenant governor of Michigan who decided that the "manly thing" to do was to legalize whorehouses, police them, and keep them inspected. He ordered our commanding colonel, to supply the medical officer. The colonel did not approve of all this, but he was outranked. Sanitation in the Army table of organization fell to the lab, and I was low man on the laboratory totem pole—not only the junior but the only unmarried officer. You can guess who was assigned the detail.

We took over four of the houses within the Medina, one a house with only native girls. All the girls had those little red tattoos in the middle of their foreheads. One of the houses outside the Medina was named the Papillon Bleu. I submit that only the French would name a whorehouse the Blue Butterfly. Prostitution was licensed in Morocco at that time, and all the girls had cards that looked like drivers' licenses with their

Dr. Watson has retired from the private practice of internal medicine/cardiology. Address correspondence to him at 4826 Maury Lane, Alexandria VA 22304.

pictures, first names, heights, weights, color of eyes, hair, etc. I do not remember surnames. Almost all of them were named Renée, Simone, Adorée, Mimi, etc. Nearly all of them were young and rather pretty. The houses were run by very capable French madams, who looked, dressed, and behaved for all the world like the rather austere French business women on the main street of Rabat. The little prostitutes were carefully trained not to show recognition of any man they might meet on the streets. I used to greet them pleasantly; they were astonished. After all, it wasn't my home town!

Dr. Merlin-Lemas was the health officer of the Pasteur Institute, which was the French name for the Rabat Health Department, was a very pleasant Frenchman with good English and very capable. I liked him immediately. He did all of the exams for venereal diseases and did them much more capably than I could have. My training was in internal medicine with the accent on cardiology, and I had had a year of pathology, and in the Army, if you knew the difference between a laboratory and a lavatory, you ended up in the lab. In Dr. Merlin-Lemas' examinations, which were conducted in the clinic building of the jail, if the girls came up with a disease or were found to have a disease, they were simply jailed until they were cured. Remember that this was before the days of penicillin and the magical drugs. We did have sulfa drugs, however.

Dr. Merlin-Lemas had no interest in body lice. We did because the body louse was the carrier of typhus. It fell to my lot to inspect the girls for lice. This is done by looking for nits attached to the pubic hair. A nit looks like a flake of dandruff and is found by shining a flashlight across the hair and flicking it with a tongue depressor; if it is firmly attached to the shaft of the hair, it is a nit. The hair is then plucked with tweezers and later examined under a microscope.

The girls were paraded in the nude by the madam. I sat on a chair with my flashlight and my tongue depressor, dressed very properly in my overseas uniform with all the tin that the Army gave us to wear. I was about 28 years old, 6′ $2\frac{1}{2}$″ tall, weighed about 130 pounds, had a doctorate in medicine, and all my specialty training behind me. The girls found this procedure hilarious. I did my very best to keep my dignity and uphold that of the U.S. Army. I did not always succeed.

Another part of my job was to supply the technician who gave prophylactics to all the customers. Each house was limited to U.S. Army personnel only; we had no Navy people. Order was kept by MPs under the command of a very unhappy-looking, very young Second Lieutenant.

I recall the madam of the Papillon Bleu—tall, dignified, about 60, a little gaunt, wore a totally black dress with a tight collar around her neck. My French was minimal, but I knew enough to say, "Bon jour." When

Lieut. John Watson and a native Moroccan in Rabat in 1943. Behind them is the Wall of Medina.
Courtesy of the author.

I finished the inspection, I would say, "Bon soir, Madam, au revoir." She would reply, "Au revoir, mon Capitan" and then add the single English phrase she knew. It had been taught to her by some G.I. wag and was so completely filthy that I cannot write it. She obviously did not know its meaning.

We thoroughly enjoyed Rabat. I would like to see it again.

We shipped out by train for Oran (Algeria) after about nine months and, after staging there, we went on to Naples; and I remained in Italy for the remainder of the war. The Italian war was serious and deadly, and our halcyon days were over.

One more word about Rabat. There was a native hospital run by the French, called L'Hopital Indigenes. The health officer, as a courtesy, asked all of our officers to visit this place, showed us patients with typhus, kalaazar, and a number of other very rare diseases. He took us into an open ward (this was a pleasant, airy building) and showed us a number of sick-looking Arabs, who appeared to have chicken pox. He, I think teasing us, said, "You gentlemen know what these patients have." None of us did. "They all have smallpox." Not a single one of us had ever seen a patient with smallpox. You have never seen a bunch of sophisticated, university doctors so obviously trying to remember the date of their most recent vaccination.

I was overseas $3\frac{1}{2}$ years. I often think that World War II was the only peaceful time in my life. All the rest of my life, I have had to compete like the devil.

Don't take our word for it...

Virginia Beach Orthopaedic Associates and
The Sports Medicine and Hand Surgery Center

Robert W. Waddell, M.D.
John L. Dobson, M.D.
Thomas S. Meade, Jr., M.D.
John A. Williamson, M.D.
Colin W. Hamilton, M.D.
Peter C. Jacobson, M.D.
Patrick W. O'Connell, M.D.
George Raymond Payne, III, M.D.

Frank G. Burns, M.D.
(Retired, 1988-89)

1553 Lila Donaldson Parkway
Virginia Beach, Virginia 23454
Appointments 481-3553

Marlene E. Jones
Administrator

November 8, 1989

Gordon D. McLean
Virginia Insurance Reciprocal
P.O. Box 31394
Richmond, VA 23294

Dear Mr. McLean:

Our office received a most generous refund on our insurance premiums the other day and I wanted to express our group's sincere thanks for it. We certainly welcome the money, and even more so, appreciate the reaffirmation that Virginia Insurance Reciprocal is indeed a company that can be trusted and is not out to "take advantage of subscribers" as is so often depicted in the news media.

This is just a brief note expressing our appreciation to Virginia Insurance Reciprocal and we hope to continue this relationship we have developed over the years.

Sincerely yours,

John A. Williamson, M.D.

John L. Dobson, M.D.

Thomas S. Meade, Jr., M.D.

Colin W. Hamilton, M.D.

Peter C. Jacobson, M.D.

G. Raymond Payne, III, M.D.

Patrick W. O'Connell, M.D.

JAW/slc

Suite 1, Bayside Professional Building, 4501 Shickshock Road, Virginia Beach, Virginia 23455
Appointments 499-9888
Suite 102, Green Run Medical Center Building, 3336 Holland Road, Virginia Beach, Virginia 23456
Appointments 464-0530

[Unsolicited testimonial from one of the many thousands of physicians' groups which received an equity return distribution during 1989.]

Call us . . . we reciprocate.

The Virginia Insurance Reciprocal

4200 Innslake Drive
Glen Allen, Virginia 23060
Toll free: 1 800 284-TVIR—In Richmond: 747-8600

POINT OF VIEW

Access: Will We Nibble at the Edges or Bite the Bullet?

THE current health-care system in the United States is under seige. Gone are the days when physicians accepted a substantial number of charitable patients and covered their expenses by cost-shifting to charges levied upon more affluent patients. Today the insurance companies and business employers, who pay much of the cost of health care, balk at such fiscal manipulations, which result in higher physician fees, hospital costs and insurance preminums.[1]

Compounding this trend is the technology explosion, which has resulted in such dramatic improvements in diagnosis and therapy but at an enormous increase in cost. An aging population with increasing numbers of Medicare recipients, at a time when government is cutting back on expenditures in Medicare and Medicaid programs. The impact of litigation, which has resulted in very high liability insurance premiums and, perhaps more importantly, the cost of defensive medicine, which is difficult, if not impossible to quantitate. The AIDS epidemic promises to create enormous financial stresses upon hospitals and physicians in the not too distant future. There is a steadily increasing literature, and concern, expressed by healthcare analysts, on the subject of inappropriate and unnecessary health-care management, which reflects seriously upon the professional ethical standards and self-policing by the medical profession.

Perhaps the most immediate problem is that of the uninsured working poor. This problem has been presented to Congress intermittently since 1974 without adequate resolution, due to congressional preoccupation with an unsolved budget deficit, ethical misconduct among the leadership, pork-barrel politics and the demands of reelection. In the seventies it was estimated that about 25 million Americans lacked insurance. A deep economic recession in the early eighties compounded the problem, and in 1986 it was estimated that 37.1 million people were uninsured in the United States, most of whom were under 65 years of age, approximately 75% of whom were working, and the remainder dependents of employed individuals who were either uninsured or had no dependent coverage. Another 30 million have inadequate insurance or do not perceive a need for it. By the year 2000 it is estimated that 60 million Americans will be uninsured.[2]

In Virginia approximately one million people are uninsured (17% of the population) whose circumstances parallel those in the national picture. The family incomes of these Virginians reveal that one-quarter have incomes between $5,000 and $10,000 annually; 40% receive $10,000-25,000 annually; and 21% earn $25,000 or more, many of whom perceive no need for insurance.[3]

The impact of such lack of coverage upon Virginia's health-care delivery system was estimated in 1986 to cost approximately $300 million, of which about one-third was borne by private hospitals but does not include the charitable contributions made by the practicing physicians within the state.[3] This is due in large part to the limited access to adequate primary care and preventive medicine by the uninsured, resulting in a disproportionate number of severely ill patients requiring hospitalization and greater than average therapy. A survey by the Virginia Hospital Association in 1988 revealed that 86% of the uninsured admissions were of an acute, emergency nature, as compared with 37% of insured admissions. Forty per cent of these patients were unable to obtain adequate outpatient care prior to admission, and it is estimated that 26% of admissions could have been prevented with adequate primary care.[3]

The impact of inadequate primary medical care is noted, particularly in those suffering from chronic, debilitating diseases. Such individuals constituted one-third of the emergency admissions and showed an admission rate 25 times that of more affluent and insured citizens.[3]

The most distressing aspect of this uninsured status is the effect upon the children. This involves 32% of the uninsured, or 11 million children in the country. Inadequate prenatal care leads to the high infant mortality rate, as compared with other democratic countries, and this is stressed by those who advocate a national health policy. Lack of well baby care, vaccination and primary pediatric care often result in dire consequences for the individual and society at large.

What should be done about it? Sen. Edward M. Kennedy has proposed a bill that would require all employers to provide health insurance coverage to their employees, thus extending coverage to an estimated two-thirds of the uninsured. Karen Davis and

Gary Robbins testified in 1987 before the Committee on Labor and Human Resources of the U.S. Senate and expressed the opinion that such a policy would cost between $23-100 billion and would result in the loss of 120,000 to one million jobs.[4] The Massachussetts experience would tend to support this assertion.[5]

The Virginia Indigent Health Care Trust Fund derives $8.9 million from the state's General Fund, and approximately $6.1 million from hospitals that provide charitable care below a given standard. It is estimated that this will provide only 6% of a projected $250 million cost of charitable care for the uninsured. This is only a token attack upon the problem and an attempt to resolve a societal problem at the expense of a very small segment of Virginia's industrial complex, i.e., the hospitals themselves, who are already providing significant charitable care.

Blue Cross and Blue Shield of Virginia is attempting to develop a low-cost insurance benefit program which should prove attractive to small business and families with limited funds. To be effective and affordable, the state-mandated benefits currently in force must be removed from this coverage.

Clearly, such efforts to resolve the problem are highly commendable but merely nibble at the edges. The size of the problem demands a more aggressive, cooperative effort between government, industry, insurance carriers, the medical field and the public. It is outrageous that millions of young American women lack prenatal care, which would cost far less than one Stealth bomber, or a fraction of our foreign aid. Eleven million children have little or no access to adequate pediatric care, while $180 billion is spent annually to support the presence of American troops, tanks and weapons in a Europe which has now recovered from World War II and has a population and a GNP at least as large as ours.

Virginia, in spite of its outstanding economic growth, which is one of the best in the Nation, is now only 42nd in its Medicaid coverage. The state's increased prosperity has resulted in the reduction of federal funds for Medicaid, while the threshold for Medicaid eligibility fell from 76% of the federal poverty level in 1975 to 39.5% in 1986. The federal non-farm poverty level for a family of four is approximately $12,000; a comparable family in Virginia would not be eligible for Medicaid if it earned $5,000 or more.

The State of Massachusetts enacted legislation in 1988 which required employers with more than five employees either to underwrite their health care premiums or pay a tax of 12% on the first $14,000 of wages to create a risk pool for those not otherwise covered. This act was passed during a period of relative prosperity, but more recent revenue shortfalls in the state have raised serious questions as to its viability.[5] Nevertheless, numerous states have viewed the Massachusetts action with considerable interest.[6]

More recently representatives from the AMA testified before Congress and recommended a pluralistic approach involving the private sector, the states, and expansion of Medicaid coverage in an attempt to deflect Congress from a comprehensive system.[7]

In 1986 a group of concerned citizens formed a nongovernmental National Leadership Commission on Health Care to assess the major problems in health care, namely, cost, quality and access to care. Their deliberations resulted in a report enunciating a proposal not unlike that proposed by the AMA, which would preserve the finest medical system in the world and ensure its availability to all Americans.[8]

I am convinced that we are rapidly approaching the crossroads. Do we accept the responsibility and active involvement in a program such as proposed above or are we prepared to do nothing and accept a comprehensive health plan similar to that in Great Britain or Canada?

We physicians still enjoy considerable prestige and political influence disproportionate to our numbers. If we are to continue to advocate the high traditional standards of our profession, then we must unite through our local, state and national medical societies and actively engage in the political process to ensure its survival.

The decision is ours. Quo vadis, Medicine?

DENNIS A. J. MOREY, MD

References

1. Rubin RJ, Moran DW, Jones KS, Hackbarth MA. Critical Condition—America's Health Care in Jeopardy, a report by Lewin/ICF, Division of Health/Sciences Research, Inc., to the National Committee for Quality Health Care. Washington DC, 1988
2. Freedman SA, Klepper BR, Duncan RP, Bell SP. Coverage of the uninsured and underinsured. N Eng J Med 1988;318(13):843-6
3. Virginia Hospital Association. Virginia's Acute Health Care Financing: A Prescription for Improvement. Richmond, Virginia, November 1988
4. Davis K, Robbins G. Economic Impact and consequences of the Minimum Health Benefits for All Workers Act of 1987. Testimony before the Committee on Labor and Human Resources, United States Senate, Nov. 4, 1987
5. Lipson DJ. Massachusetts legislation: a model for other states or a costly mistake? Business & Health 1988;5:48-9
6. Cranford G. Health insurance coverage for all in New York proposed by Commissioner. Physician Financial News 1989; 7:2
7. AMA proposes a new safety net (editorial). AMA News, November 17, 1989
8. National Leadership Commission on Health Care. For the Health of a Nation—a Shared Responsibility. Ann Arbor, Michigan, Health Administration Press Perspectives, 1989

Dr. Morey retired recently from his practice of gastroenterology and is now legislative representative for Henrico Doctors Hospital, Richmond. Address correspondence to him at 2870 Braidwood Road, Richmond VA 23225.

Eosinophilia, Myalgia Associated with L-Tryptophan Use: Case Report

Daniel M. Becker, MD,
Saleha Habib-Hong, MD, and
Stephen M. Smith, MD,
Charlottesville, Virginia

On November 11, 1989, the Food and Drug Administration issued a warning that L-tryptophan use may be associated with eosinophilia and severe myalgia after 30 reports of this syndrome had been reported from six western states.[1,2] Since we could find no detailed clinical descriptions of such patients, including their responses to corticosteroids, we here share our experience, beginning in September 1989, in the treatment of a patient with eosinophilia and myalgia who, it turned out, had been using L-tryptophan.

Case Report

A 42-year-old white female previously in excellent health presented on September 6, 1989, with a 4-day history of fever, myalgia and arthralgia after vacationing on eastern Long Island. There were no respiratory or dermatological symptoms. She and her husband had noticed swollen eyes during the first few days of this illness. She denied tick bites, although tick exposure was likely. She had taken a single dose of an oral penicillin for her symptoms, and the only other medication was L-tryptophan (2 grams QHS), which she had been using each night since July 1989 to help her sleep. She obtained this medication without prescription at a local health food store. On physical examination in the office she was afebrile. There was no lymphadenopathy, rash, synovitis, muscle weakness or tenderness. Laboratory results for this visit and others are summarized in Table 1. On September 8 she felt worse and had developed mild orthopnea but no cough. On examination she had faint bibasilar rales and lymphadenopathy. Small (<0.5 cm), nontender, moveable cervical, supraclavicular, axillary and epitrochlear lymph nodes were felt. Her chest x-ray (Fig. 1) showed interstitial pneumonitis with bilateral blunting of the costophrenic angles. The total white count

From the Department of Medicine, University of Virginia School of Medicine. Address correspondence to Dr. Becker at Box 494, University of Virginia Health Sciences Center, Charlottesville VA 22908.

Submitted 11-29-89.

Fig. 1. Chest x-ray showing bilateral interstitial pneumonitis with costophrenic blunting.

was 10.1 K/uL with distinct eosinophilia (15%). Erythromycin (250 mg po QID) was given for 7 days, and while her chest x-ray cleared, she remained ill. On September 14 her transaminases were measured and noted to be elevated.

She was admitted to the University of Virginia Hospital from September 22 through 26 for detailed evaluation. At this time her predominant symptoms were myalgia and arthralgia. She was afebrile in the hospital, and had a transient (one night) pruritic erythematous rash. The lymphadenopathy was still present. There was no synovitis, weakness or muscle tenderness. Marked eosinophilia persisted (Table 1). Her transaminase determinations were lower. The erythrocyte sedimentation rate was elevated, but rheumatoid factor and antinuclear antibody (mouse and human substrate) were not detectable. Total complement was normal, and the anti-Clq assay for immune complexes was also normal. Fasting cortisol was normal, and her PPD skin test was negative with a reactive anergy panel. A Borrelia burgdorferi titer (measured by the Mayo Clinic laboratory) was less than 250 antibody response units and considered negative for Lyme disease. There was no evidence for parasite infestation: Stool for ova and parasites was negative repeatedly; toxocara and trichinella antibodies were negative; a string test of duodenal contents was negative for strongyloides and other parasites; total IgE was normal. Visceral larva migrans was nevertheless the leading diagnosis, and she was given thiabendazole (500 mg BID for 3 days). This treatment did not elicit a pruritic response. Use of nonsteroidal antiinflammatory agents provided minimal relief of muscle and joint pain. She was given lorazepam (0.5 mg) in lieu of L-tryptophan for sleep.

At this point in the illness there was still no diagnosis. The patient remained almost totally disabled with

Table 1. Clinical and Laboratory Findings.

Month	September					October			November	
Day	6	8	14	22	25	2	10	19	14	22
Clinical Features										
Temperature (°C)	38.2	Afebrile after September 14								
Weight (kg)	52.5			51.0		49.7		46.6		48.5
Lymphadenopathy	None	↑	↑	↓		slight		none		
Myalgia	Throughout ---------->									
Arthralgia	Throughout ---------->									
Laboratory Results										
Hemoglobin (g/dL)	13.3	11.6	13.0	12.7	12.4	12.1	13.4	14.0	12.9	11.6
Hematocrit (%)	40.0	35.0	40.0	39.0	37.6	37.0	41.0	43.0	39.2	35.8
WBC (K/μL)	9.3	10.1	21.2	21.0	17.7	12.6	11.8	16.5	6.5	6.7
Eosinophils (% total WBC)	8	15	29	56	55	40	0	2	0	4
ESR* (mm/h)				66		12				
AST† (U/L, normal 7-40)			103	52		39	17			
ALT† (U/L, normal 6-65)			163	95		60	53			
LDH (U/L, normal 230-450)				748		659	379			
CK (U/L, normal 30-200)				15		17				
Aldolase (U/L, normal 2.5-14.0)						4.8				

* ESR-erythrocyte sedimentation rate † transaminases: AST-SGOT, ALT-SGPT

myalgia, arthralgia and fatigue, and the eosinophil count remained perplexingly elevated. Largely to exclude lymphoma, a left axillary lymph node was excised on October 4. The histopathology was negative for lymphoma or granuloma, and all cultures (mycobacteria and fungal) have been negative. Symptomatic treatment with prednisone (20 mg BID) was initiated on October 6 for what seemed to be serum-sickness with an unknown precipitant. The patient's symptoms improved within 72 hours of beginning corticosteroids. As expected, the eosinophilia disappeared with initiation of prednisone. Within a week the patient stated she was "90% improved" in terms of muscle and joint pain. Because of persistent muscle pain and subjective muscle weakness, an EMG was performed on October 12. There was no evidence of myositis or neuropathy on this study. She developed muscle cramping at the time prednisone was started, and this symptom seemed to respond to quinine sulfate (200 mg BID). With the clinical improvement and the lack of evidence for a systemic vasculitis, the corticosteroids were tapered relatively quickly, and her last dose of prednisone was on November 12. The same day the local newspaper printed an Associated Press story linking L-tryptophan to an illness identical to that described in this report.[1] The patient read the story, made the diagnosis, and informed her physicians. At the time this was written the patient had been off corticosteroids for 10 days and had continued to improve. Her eosinophilia did not reappear.

Discussion

In this case what seemed initially to be a viral syndrome evolved into a 10-week diagnostic dilemma with pneumonitis, lymphadenopathy, hepatitis, myalgia, arthralgia and persistent eosinophilia. Investigations into the cause of this illness focused on the laboratory finding of eosinophilia. As listed in Table 2, there are many diverse causes of eosinophilia.[3-5] While many of these could be excluded on clinical grounds, it seemed necessary to search compulsively for helminthic infestation, to look for serological evidence of a systemic vasculitis, and to biopsy an enlarged lymph node when persistent symptoms made lymphoma an ominous possibility. Despite the wide range of diagnostic possibilities, the clinical picture did not clearly match any of the described causes of eosinophilia. While the patient had hypereosinophilia, she did not have it long enough for either a diagnosis of idiopathic hypereosinophilic syndrome or the more morbid end-organ manifestations (cardiac, CNS) of this entity.[5,6]

Once the link between L-tryptophan and eosinophilia was recognized, the diagnosis in this case became obvious. Our patient fits the case definition proposed by the Centers for Disease Control.[2] While eosinophilia and myositis have been reported previously, this association has been rare and usually noted as a manifestation of idiopathic hypereosinophilia syndrome[7,8] or as a feature of focal myositis.[9] The triad of eosinophilia, myositis and pneumonitis has been reported but is also rare.[10]

The pathogenesis of L-tryptophan associated eosin-

Table 2. Disorders Associated with Eosinophilia

- Allergy or hypersensitivity
  - Asthma
  - Seasonal rhinitis
  - Drug reactions
- Parasitic disease
  - Strongyloidiasis
  - Trichinosis
  - Schistosomiasis
  - Toxocara
  - Filariasis
- Connective tissue disease
  - Necrotizing vasculitis
  - Eosinophilia with fasciitis
  - Rheumatoid arthritis
  - Systemic lupus erythematosus
- Idiopathic hypereosinophilia syndrome
- Neoplasia
  - Hodgkin's disease
  - Mycosis fungoides
  - Acute lymphoblastic leukemia
- Sezary syndrome
  - Solid tumors
- Cutaneous disease
  - Allergy
  - Dermatitis herpetiformis
- Immunodeficiency disease
  - Wiscott-Aldrich syndrome
- Hyper-IgE with infection
  - IgA deficiency
- Endocrine disease
  - Adrenal insufficiency
  - Pituitary insufficiency

ophilia and myalgia is not known. The widely reported toxic-oil outbreak in Spain in 1981 established precedent for a toxin-induced neuromuscular illness with eosinophilia, hepatitis, pneumonitis, and weight loss.[11] To date there is not enough clinical information to anticipate the natural history of L-tryptophan-associated eosinophilia and myalgia. While our patient has improved significantly with corticosteroids and withdrawal of L-tryptophan, she still suffers from fatigue and muscle pain. In the toxic-oil outbreak, prolonged neuromuscular symptoms were not uncommon.

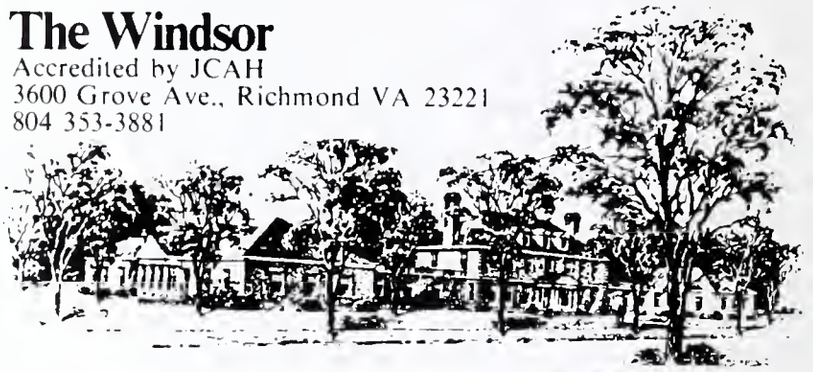
The CDC learned of 154 cases within the first few days of its initial report.[2] We have learned of three other patients with this syndrome in the past week. Undoubtedly, physicians in practice will encounter patients with disabling myalgia and arthralgia. Eosinophilia should be sought and the medication history reviewed carefully. Corticosteroids should be considered once L-tryptophan use and eosinophilia are noted. Because the symptoms are frequently disabling, treatment should not be delayed pending an exhaustive evaluation of the myriad causes of eosinophilia. However, since some infections that cause eosinophilia are made worse by corticosteroids (e.g., tuberculosis, strongyloidiasis), the initial evaluation should include PPD skin testing and stool examination for parasites. As physicians in practice become familiar with this new syndrome, early diagnosis and treatment can replace the painful odyssey of our patient.

References

1. The Daily Progress, Charlottesville, Virginia, p A-2, November 12, 1989
2. Eosinophilia-myalgia syndrome-New Mexico. CDC Morbidity and Mortality Weekly Report 1989;38:765-766
3. Spry CFJ. New properties and roles for eosinophils in disease: discussion paper. J R Soc Med 1985;78:844-848
4. Tavassoli M. Eosinophil, eosinophilia, and eosinophilic disorders. CRC Crit Rev Clin Lab Sci 1981:35-83
5. Harley JB. The clinical manifestations of patients with hypereosinophilic syndrome. *In* (Fauci AS, moderator.) The idiopathic hypereosinophilic syndrome: clinical, pathophysiologic, and therapeutic considerations. Ann Intern Med 1982;97:78-92
6. Schwartz LB. Hypereosinophilic syndrome: a review. Va Med 1984;111:350-355
7. Layzer RB, Shearn MA, Satya-Murti S. Eosinophilic polymyositis. Ann Neurol 1977;1:65-71
8. Stark RJ. Eosinophilic polymyositis. Arch Neurol 1977; 36:721-722
9. Yonker RA, Panush RS. Idiopathic eosinophilic myositis with preexisting fibromyalgia. J Rheumatol 1985;12: 165-167
10. Lakhanpal S, Duffy J, Engel A. Eosinophilia associated with perimyositis and pneumonitis. Mayo Clin Proc 1988;63:37-41
11. Kilbourne EM, Rigau-Perez JG, Heath CWjr et al. Clinical epidemiology of toxic-oil syndrome: manifestations of a new illness. N Engl J Med 1983;309:1408-1414

LONG-TERM CARE: IN SIXTH DECADE OF EXCELLENCE

The Windsor
Accredited by JCAH
3600 Grove Ave., Richmond VA 23221
804 353-3881



Mrs. Plyler's
Residential Care
1615 Grove Ave., Richmond VA 23220
804 353-3981

University Park
Accredited by JCAH
2420 Pemberton Rd., Richmond VA 23233
804 747-9200

ABSTRACTS

The following abstracts are to be presented at the regional meeting of the Virginia Chapter, American College of Physicians, and the Virginia Society of Internal Medicine on March 24 in Richmond. Dr. Donald MacLean Switz is program chairman.

Toxic Shock Syndrome with Acute Renal Failure Secondary to Group A Beta-Hemolytic Streptococcal Exudative Pharyngitis. David J. Thaler, DO, and Joseph Snyder, MD, *Portsmouth.*

The toxic shock syndrome has been shown to result from exposure to bacterial exotoxins, and, previously, from infection with *Staphlococcus aureus*. A cluster of cases has recently been reported in the western United States involving group A beta-hemolytic streptococcal skin or musculoskeletal infections including cellulitis, infected surgical wounds and suppurative thrombophlebitis, as well as peritoneal and pharyngeal infection. The cases of pharyngitis all involved other concurrent sites of infection, including endophthalmitis and myositis.

We report a case of toxic shock syndrome secondary to culture-proven group A beta-hemolytic streptococcal exudative pharyngitis. The case occurred in eastern Virginia and the patient had no significant travel history. The patient presented with all the classical symptoms of toxic shock syndrome, including hemodynamic instability, rash, hypocalcemia, hypokalemia and renal and liver dysfunction. Cultures of the blood and urine failed to yield an organism; however, the patient had a marked exudative pharyngitis which yielded group A beta-hemolytic streptococcus by routine culture. No infected sites could be identified. Renal dysfunction was not associated with a nephritic sediment as would be expected in a poststreptococcal glomerulonephritis. The complements were all within normal limits. This case may demonstrate a new pattern and association for toxic shock syndrome and must be considered now in patients presenting with group A beta-hemolytic streptococcal pharyngitis and renal failure.

Acquired Toxic Methemoglobinemia and Pulse Oximetry: Clues to Diagnosis in a Paradoxical Resuscitation Puzzle. Alan Rolfe, MD, *Portsmouth.*

Pulse oximetry is a simple noninvasive method for continuous monitoring of hemoglobin (Hb) saturation, and is an indirect measure of arterial P_AO_2. Although this form of monitoring is now a standard of care in intensive care settings and for patients undergoing surgical anesthesia, endoscopy, bronchoscopy, and mechanical ventilation, internists and subspecialists who use pulse oximetry monitoring should be aware of both its advantages and its limitations.

Acquired toxic methemoglobinemia (ATM) with severe cyanosis is potentially fatal but is easily curable if it is correctly diagnosed. In this condition, the physical appearance, pulse oximetry saturation, arterial P_AO_2, and calculated Hb saturation present a paradox. A 24-year-old white male developed cyanosis after elective intubation and anesthetic induction. Pulse oximetry indicated Hb saturation levels of 82%. Usual resuscitation measures failed to reverse the patient's cyanosis despite documented arterial P_AO_2 of 564 torr and 100% calculated Hb saturation on 100% FIO_2. Hb analysis revealed 26% methemoglobin which was treated with intravenous methylene blue. Topical benzocaine used for local anesthesia prior to nasotracheal intubation was retrospectively identified as the cause.

A review of case reports in the literature of ATM revealed significant delays in diagnosis; delays averaged 2 hours and exposed many patients to intensive and hazardous resuscitation procedures. Low pulse oximeter saturations should alert physicians to the presence of unsuspected methemoglobinemia in the appropriate clinical setting. A brief discussion of pulse oximetry is presented. The pathophysiology underlying this resuscitation puzzle and the basis of treatment of ATM are reviewed.

Modern Day Pellagra in South Hampton Roads. Joseph Czerkawski, MD, and Herschel Estep, MD, *Norfolk.*

Classical pellagra once endemic in Southern U.S. is rarely diagnosed nowadays. After seeing a case of pellagra, we wondered about occurrence of this disorder in modern times. We examined the records of cases of niacin deficiency diagnosed in South Hampton Roads hospitals between years 1981 through 1989. Only nine cases of pellagra were recorded during this time, 4 cases showing all classic manifestations, and 5 cases having features of niacin deficiency excluding rash. Compared to a series when pellagra was endemic (1912-1944), we report that the average age is now older (60 vs 40 years), mental status changes are much more frequent (100% vs 26%), but the classic skin manifestations are seen in only 45% of our patients versus 85% from prior series. Alcoholics made up our entire population, which was not true in the earlier series. Both series established the diagnosis of pellegra on the basis of clinical manifestations, as biochemical criteria were not helpful in establishing the diagnosis. Furthermore, it is likely that patients in our series received suboptimal doses of nicotinamide.

Conclusion: We suggest that classic manifestations

of modern day pellagra may be present with niacin deficiency. However, the disorder should be considered in alcoholic patients with mental status changes with or without other commonly accepted classical manifestations.

Intramural Hematoma of the Gastrointestinal Tract: Case Report and Review of the Literature. Michael P. Jones, MD, *Richmond.*

Intramural hematomas of the gastrointestinal tract are uncommon. Fewer than 350 cases have been reported to date. Two-thirds of these are related to blunt abdominal trauma, but an increasing number of cases are seen in patients receiving anticoagulants. We present the case of a patient with a spontaneous jejunal hematoma secondary to coumadin intoxication.

A 66-year-old male taking coumadin for recurrent thromboembolic disease presented with the sudden onset of abdominal pain, nausea and vomiting. There was no history of trauma. Abdominal examination revealed diffuse tenderness and guarding without mass or peritoneal signs. NG tube aspirate and rectal examination revealed no evidence of bleeding. There was no clinical or laboratory evidence of biliary or pancreatic disease. The prothrombin time was increased to 38 seconds. CT scan of the abdomen revealed a large hematoma involving the proximal jejunum with extension into the mesentery. The patient was managed supportively with NG tube decompression, intravenous fluids and correction of his coagulopathy. His condition rapidly improved over the next several days and he was discharged. An upper gastrointestinal series obtained one month after discharge revealed resolution of the lesion.

A review of intramural hematomas of the gastrointestinal tract with respect to etiology, clinical and radiographic features and management will be presented.

Inhibition of Cardiac Allograft Atherosclerosis by Dehydroepiandrosterone. D. M. Eich, MD, D. E. Johnson, MD, J. E. Nestler, MD, D. Ko, MD, M. L. Hess, MD, and A. S. Wechsler, MD, *Richmond.*

Accelerated atherosclerosis (CAD) is a major cause of morbidity and mortality in cardiac transplantation. Dehydroepiandrosterone (DHEA) is an endogenously produced hormone which has been shown to decrease atherosclerosis in animals. We examined whether DHEA could inhibit CAD using outbred rabbits with heterotopically transplanted hearts. Accelerated atherosclerosis was produced by feeding these animals a 1% cholesterol diet. The animals were immunosuppressed with cyclosporine (5 mg/kg) and azathioprine (1 mg/kg), and they were randomly divided into 4 treatment groups: 1) low cholesterol diet, n = 5, 2) 1% cholesterol n = 5; 3) low cholesterol 0.5% DHEA, n = 5, and 4) 1% cholesterol + 0.5 DHEA, n = 7. The animals were sacrificed at 5 weeks, and the hearts were perfused at systemic pressure. The hearts were fixed in 10% formalin, the entire coronary arterial tree was cross-sectioned and microscopic slides were prepared. Morphometry was performed on the arterial sections (n = 840) and the percent cross sectional luminal area stenosis was calculated. The mean percent stenosis was 32% in Group 2 and 9% in Group 4. Thus the coronary arteries of the Group 4 animals showed a 72% decrease in luminal stenosis as compared to Group 2 ($p. < .01$). There was no significant atherosclerosis in Groups 1 and 3. We conclude: DHEA inhibits accelerated atherosclerosis in this transplant model.

Adrenal Insufficiency Secondary to Disseminated Cryptococcus Neoformans in a Nonimmunocompromised Host. Sharon M. Messics, MD, and Richard K. Sterling, MD, *Richmond.*

Destruction of the adrenal cortex, regardless of the nature of the underlying process, leads to primary adrenal insufficiency. The leading causes of primary adrenal insufficiency are autoimmune disorders and tuberculosis. Other less common causes include neoplasm, hemorrhage, amyloidosis, and fungal infections. We present a case of disseminated *Cryptococcus neoformans* as a cause of primary adrenal insufficiency in a nonimmunocompromised host, without evidence of pulmonary infection nor obvious exposure to the organism. Diagnosis of adrenal insufficiency was made by appropriate ACTH and cortiscol levels, and histology of adrenal tissue, obtained by computed tomographic (CT)-guided needle aspiration, revealed the presence of *Crypotococcus neoformans.* To the best of our knowledge, this is the fourth reported antemortem biochemically and histopathologically proven case of cryptococcal-induced adrenal insufficiency.

Effect of Residual Antegrade Coronary Flow on LV Function, Myocardial Perfusion, and Survival after Uncomplicated Myocardial Infarction. James D. Bergin, MD, and Robert S. Gibson, MD, *Charlottesville.*

The effect of residual antegrade coronary flow on LV function and perfusion (at 10 d and 3 mos), and on mortality during 43 ± 18 mos of follow up was examined in 190 consecutive pts (age ≤65 yrs) with MBCK confirmed acute uncomplicated MI. All pts were prospectively evaluated with cardiac cath, 24 hr Holter, rest radionuclide ventriculography (RVG) and either exercise (GXT, n = 179 or rest (in = 11) Tl-201 scintigraphy within 3 d of hospital discharge (11 ± 3d). RVG and Tl-201 studies were repeated at 3 mo. No pt received thrombolytic therapy, or underwent PTCA or CABG prior to the 3 mo studies. For purposes of analysis, pts were grouped according to the presence (G1, n = 64 [34%]) or absence (G2, n = 126) of TIMI grade 2-3 flow in the infarct related artery (IRA). There were no differences between the 2 groups in age,

prevalence of prior MI or angina, peak CK (measured q4 hrs), Killip class in the CCU, or Lown grade ≥ 3 arrhythmias at 8 ± 3d. Also, G1-2 pts had similar 10 d/3 mo GXT findings (exercise duration, peak RPP or workload achieved, angina and/or ST seg depression), and Tl-201 evidence of increased lung uptake and multivessel disease (MVD). However, G1 pts did have lower angio Jeopardy scores ($p < .05$) and less angio evidence of MVD ($p < .01$). G1 pts with LAD infarcts had higher LVEFs on both the 10 d and 3 mo RVG study (48% vs 39% and 48% vs 40%; $p < .05$), but no such difference was noted between G1-2 pts with RCA or LCX infarcts. Further, no difference in LV size was found in any G1-2 subgroup at 10 d or 3 mos. Tl-201 studies at 10 d and 3 mo revealed fewer scan segs with persistent defects ($p = .04$ and $p = .03$) and more scan segs with redistribution ($p = .003$ and $p = .036$) in G1 pts. Kaplan-Meier life table analysis showed similar reinfarction rates between G1-2; however, survival was better (.93 vs .81, $p = .015$ [Breslow]) among G1 pts. Significant independent predictors of survival (Cox regression analysis [86 variables]) included smaller infarct size by Tl-201 and RVG criteria, improvement in infarct zone asynergy between 10 d and 3 mo. absence of reinfarction, and a patent IRA.

Thus residual antegrade coronary flow is associated with less Tl-201 evidence of myonecrosis, better LV function in LAD infarcts, and is an independent predictor of improved long term survival.

Secondary Gastric Syphilis in a Human Immunodeficiency Virus Type I (HIV-I) Coinfected. Dorothy C. Garner, MD, J. Boyd Francis, MD, and Charles J. Schleupner, MD, *Roanoke*.

The natural history and response to therapy of syphilis may be altered by coinfection with HIV-I. In patients with underlying HIV-I infection, syphilis has been documented to progress from initial infection to neurosyphilis in less than 6 months. Furthermore, progression to neurosyphilis has been documented in HIV-I coinfected patients despite standard treatment with intramuscular benzathine penicillin.

We report a 27-year-old HIV-I antibody-positive black male with a radiographically demonstrated antral ulcer which failed to respond to conventional treatment. Esophagogastroduodenoscopy (EGD) with biopsy revealed multiple polypoid masses in the body and antrum of the stomach, which histologically showed a dense chronic inflammatory infiltrate, consisting primarily of plasma cells. Subsequently the patient's reactive protein reagin (RPR) was found to be positive at a titer of 1:512. Silver stains of the gastric biopsy revealed numerous spirochetes in the lamina propria. Intravenous penicillin therapy was followed by prompt resolution of symptoms. This patient's clinical syndrome fulfills all of the criteria for the diagnosis of gastric syphilis. This case emphasizes that the presentation and natural history of syphilis may be altered in patients with HIV-I coinfection. The implications regarding clinical management of patients with *Treponema pallidum* and HIV-I coinfection will be discussed.

Phlegmasia Cerulea Dolens: Familial Protein S Deficiency and Thombolytic Therapy. Linda G. Philpot, MD, Donald Dinous, MD, Jesse Davison, MD, and Charles L. Crockett, Jr., MD, *Roanoke*.

Protein S is a vitamin K-dependent cofactor of activated protein C, which acts in the clotting cascade to inhibit clotting at the level of factors Va and VIIIa. Inheritable deficiency of protein S has been recognized since 1981, the clinical implication of which is thrombophilia. To our knowledge this is one of the first reported cases of phlegmasia cerulea doleus in the medical literature in a young patient with protein S deficiency.

A previously healthy 18-year-old athletic white male developed abrupt onset of a painful, blue left leg without obvious precipitating causes. Thigh diameters differed by 10 cm and the entire affected limb was grossly cyanotic, tender and edematous. Arterial pulses were present and confirmed by Doppler. Duplex scan demonstrated no flow in the left leg including iliac, common and deep femoral, popliteal and greater saphenous veins. Aggressive thrombolytic therapy with urokinase was initiated and improvement of symptoms and disappearance of cyanosis was noted within 12 hours. Slight flow in the deep femoral vein was present on the second hospital day and clinical improvement continued. After a 5-day course of thrombolytic therapy he was placed on IV heparin. Repeat Duplex scan demonstrated clot maturation and patency of the femoral system. He was discharged home anticoagulated on oral warfarin. Blood studies indicated absent free protein S and low normal levels of the bound (total) form. Further studies confirmed his father to have only a trace of protein S but no clinical events.

Young individuals presenting with venous thrombosis should be avaluated for inheritable and other hypercoagulable states. Thrombolytic therapy may be limb-saving in phlegmasia cerulea dolens.

Prevalence of and Variables Associated with Silent Ischemia on Exercise Thallium-201 Testing. Christine Gasperetti, MD, Lawrence Burwell, MD, and George Beller, MD, *Charlottesville*.

We prospectively studied 103 consecutive patients undergoing symptom-limited exercise thallium-201 testing to identify those variables which correlated with the presence of silent ischemia (SI). Fifty-nine patients (57%) had SI on testing. Silent ischemia was defined as presence of a Tl-201 redistribution defect in absence of chest pain. There was no difference between SI and angina (AP) groups with respect to age,

sex, antianginal use, prevalence of diabetes mellitus, and exercise parameters including duration, METS or heart rate achieved, peak workload or peak double product.

A significantly higher percentage of SI patients had a recent myocardial infarction (31 vs 7%, $p < 0.01$), had no prior angina (64 vs 91%, $p < 0.01$), had dyspnea as an exercise endpoint (50 vs 35%, $p < 0.05$), and had redistribution in the supply regions of the right or left circumflex (50 vs 35%, $p < 0.05$) coronary arteries. Patients with AP had a significantly greater incidence of ST depression (64 vs 41%, $p < 0.05$). There was no difference between the two groups with respect to total Tl-201 perfusion score, number of redistribution defects per patient, multivessel redistribution pattern, or extent of angiographic coronary artery disease (CAD).

In conclusion, we report a high prevalence of SI by exercise thallium testing. This occurs independently of exercise performance parameters, extent of angiographic CAD, and extent of exercise-induced scintigraphic defects.

Adenocarcinoma Presenting as Endocarditis. Brian Bachhuber, MD, and Munsey S. Wheby, MD, *Charlottesville.*

The hypercoagulable state and nonbacterial thrombotic endocarditis (NBTE) are known complications of cancer. We present an unusual and instructive case of a previously healthy 44-year-old white woman with a clinical syndrome of fever, malaise, anemia, transient pleural effusions, splinter hemorrhages, hematuria/proteinuria, and acute onset of a left homonymous hemianopsia. Screening coagulation studies were normal. Head CT, abdominal CT, and abdominal aortogram were felt consistent with arterial embolic disease. Echocardiogram and Doppler study revealed an aortic vegetation with mild AI. Cultures of blood, urine and CSF were persistently negative and broad spectrum antibiotics failed to control the fever. Review of the abdominal CT suggested evidence of left deep vein thrombosis (DVT) and question of pulmonary infarction. Ultrasound showed bilateral leg DVT. Needle biopsy with ultrasound guidance of a hypodense liver lesion revealed poorly differentiated adenocarcinoma.

In this case of carcinoma-induced NBTE and hypercoagulability, the presentation was that of "culture negative endocarditis (CNE)." Initial management for the former, heparin, is contraindicated in bacterial endocarditis. We suggest that in CNE one must be wary of NBTE and the diseases associated with that condition—in this case, adenocarcinoma.

TRIP OF A LIFETIME RAFFLE

sponsored by

the Medical Society of Virginia and the MSV Auxiliary

Free trip for two to South America, airfare and hotel paid, to the lucky winner of the drawing on May 2, 1990.

TO ENTER YOUR NAME IN THE DRAWING:

1. Your check for your MSV dues 1989–1990 must be received at MSV headquarters no later than April 20, 1990. If you haven't paid your dues, dig out the statement sent to you in December or watch for the second billing going into the mail this month.

2. If you are married, your spouse must be a dues-paid member of the MSV Auxiliary as of April 20, 1990. Check with your spouse. Are her/his Auxiliary dues paid? If not, and you wish to pay them, send a separate check for $28 payable to the Medical Society of Virginia Auxiliary to Gail L. Tiesenga, MSVA Treasurer, 375 Middle Street, Portsmouth VA 23704.

Questions about MSV dues? Call Mrs. Nancy Renalds, 804-353-2721.
Questions about MSVA dues? Call Mrs. Tiesenga, 804-393-9453.

VIRGINIA MEDICAL

Medical Care Here and There

ARE YOU dissatisfied with the way you must practice medicine? Do you hate government and big business controls? Have you had it up to here with insurance requirements? Are you constantly worried that some patient, dissatisfied with less than a perfect result, will institute a malpractice suit? If so, see the three-part "Medicine Abroad" in this issue; you are bound to feel better. For the physician, the United States remains the medical Valhalla.

What about the patient? Does the United States system supply optimal health care for all? Unfortunately, it does not, but optimal care is available. Our problem lies in access to medical care. Both the British and Canadian health care systems provide excellent programs, but there is some question as to access in them; each appears to involve rationing of health care.

Sometime in March or early April 1990 (date and place not yet available), St. Mary's Hospital, Richmond, will sponsor a program including presentations of both the Canadian and British health care systems. The speakers will be authoritative and there will be a question and answer period. Watch for the announcement.

E.L.K. JR.

The Ideal Family Physician

I NEVER knew him, but over the years I have heard a lot of stories about him.

He was the ideal country doctor: capable, compassionate, sincere, always available, and very affordable. He had been well-trained at one of the larger medical schools, where he stayed for many years to teach. Eventually he could no longer tolerate the city and returned to his rural home in a nearby county.

By then he was an elderly bachelor with no living relatives and with few interests outside medicine. He always worked slowly and methodically, giving each and every patient a full share of his unhurried time.

His very modest home was next door to his even more modest one-room office which was so small that he had to go outside on the porch, winter or summer, while his women patients undressed or dressed.

He had a one-man operation with no overhead for nurse or secretary. He dispensed a few medications, but he did not need many because this was before our pharmaceutical armamentarium had much therapeutic value. No insurance forms to fill out because there was no health insurance.

Even for those days his price was reasonable at $.25 for children and $.50 for adults, with liberal credit and plenty of charity. The hungry, down-on-their-luck people could always turn to him for a meal and a little pocket change.

He was greatly loved and respected in his community, and the people grieved when he became too ill and feeble to continue his medical practice, when he could no longer attend to their medical problems at any time of day or night, when they had to travel 20 miles to see someone who would charge them $5 a visit. Oh, it was quite a shock to the community to see him close his office for the final time.

Only one year later he died, alone, in the county poor house for the elderly.

HENRY S. CAMPELL, MD

OBITUARY

Memoir of S. F. Driver 1905-1989

By Julian B. Doss, MD

Samuel Francis Driver, MD, was born September 20, 1905, in Staunton, Virginia, and died September 22, 1989, in Roanoke. He was a graduate of Bridgewater College, Class of 1927, where he was active in student government. He was business manager of the annual and captain of the football team. He taught at Elkton High School from 1927 to 1928 and was principal of Deerfield High School in 1928 and 1929. He matriculated at the Medical College of Virginia in the fall of 1929 and earned the MD degree in 1933. His initial practice at Troutville, Virginia, followed a brief internship at Lewis-Gale Hospital in 1933.

He was called to serve in the Army Medical Corps in January 1942 as captain and commanding officer of the 672nd Medical Collecting Company in the Italian Campaign April 1944 to August 1945 and was awarded the Bronze Star for meritorius service in the Poe Valley breakthrough action.

On returning home, he established his practice on Williamson Road in 1946, where he served for the next 25 years. He was active in the progress of medicine. He served as secretary of the Blue Ridge Academy of Medicine and as secretary-treasurer of the Roanoke Academy of Medicine.

He was a member also of The Medical Society of Virginia, the Virginia Academy of Family Practice, and the American Medical Association.

Other activities included church Bible teacher, president of the Williamson Road Lions Club, member of the First Presbyterian Church, and other community affairs. He was an avid fisherman and played some golf. He joined the staff of the Veterans Administration Medical Center in Salem, Virginia, in 1960. He was acting chief of staff at the Mental Hygiene Clinic for the next 20 years. He received a commendation for meritorious service. On retiring, he continued part-time service with the Social Security Disability Board.

Dr. Driver was a beloved family physician, warm, caring and diligent. He was active in the advancement of medicine in days of limitations, unproven procedures and medications, and when travel was time-consuming and conditions difficult—at time impossible—in mountainous terrain and inclement weather.

He was blessed with a devoted, constant companion in his wife, Elizabeth Kinzie Drive, and celebrated their sixtieth anniversary a few days prior to his death. He is survived also by daughter, Eleanor Frances Driver Arnold, two grandsons, Charles Arnold III and Samuel Driver Arnold, and a sister, Rachael Driver Murphy.

• **Monford D. Custer, Jr., MD,** Winchester surgeon; Columbia University College of Physicians and Surgeons, 1940; age 74; died November 23, 1989.

• **Levi W. Hulley, Jr., MD,** Richmond; University of Virginia School of Medicine, 1939; age 75; died December 10, 1989. By specialty a family physician, Dr. Hulley had for many years been a medical administrator.

• **Edgar Willis Lacy, Jr., MD,** Winchester internist; Medical College of Virginia, 1936; age 81; died November 24, 1989.

• **Quentin J. Legg, MD,** Newport News radiologist; Medical College of Virginia, 1943; age 70; died November 16, 1989.

• **John J. O'Connor, MD,** retired anesthesiologist at Alexandria Hospital; State University of New York at Buffalo, 1950; age 69; died December 1, 1989. He was a past president of the Alexandria Medical Society.

Help for a troubled friend is only a phone call away.

If you suspect a colleague is experiencing problems with alcohol or drug abuse, don't contribute to the "conspiracy of silence," call The Medical Society of Virginia's Physicians' Health and Effectiveness Committee. A non-punitive approach through rehabilitation *is* an alternative. Your report will be kept confidential. Ask for Jeanne Douglas at MSV headquarters, (804) 353-2721.

The Personality Disorder Treatment Program of Sheppard Pratt Hospital

Very often, specialized inpatient evaluation and treatment is a critical step in the effective long-term care of a borderline patient.

The Personality Disorder Treatment Program at Sheppard Pratt offers a combination of services that may help to untangle difficult clinical questions and facilitate your patient's continued outpatient treatment.

We offer:

- ☐ Extended stay intensive inpatient treatment
- ☐ Intermediate stay crisis intervention
- ☐ Comprehensive diagnostic evaluation
- ☐ Psychopharmacology evaluation and treatment
- ☐ Psychotherapy consultation

If you would like to know more about the Sheppard Pratt approach to the borderline patient and other patients with severe personality disorders, contact the Adult Admissions Office at:

(301) 938-3800
6501 North Charles Street
Baltimore, Maryland 21285-5815

▪ *Sheppard Pratt*
A not-for-profit health system

MEETINGS

February 23-25
Pediatric Emergency Medicine (Virginia Chapter, American Academy of Pediatrics and Virginia Pediatric Society), *Williamsburg*. 13 hrs. credit. Judy Suher, (804) 643-8130.

February 25-March 3
4th Annual Innovations in the Diagnosis and Treatment of Gastrointestinal Disorders (Georgetown University), *Vail, Colorado*. CME Office, 202-687-8735.

March 3
4th Annual Peripheral Vascular Disease Symposium (Fairfax Hospital/Georgetown University), *Falls Church*. 3 credit hrs. Fee, $40. Cathy Sarraf, 703-698-2572.

March 5-8
Alton D. Brashear Postgraduate Course in Head and Neck Anatomy (Medical College of Virginia/VCU), *Richmond*. Hugo R. Seibel, PhD, 804-786-9624.

March 8-11
Controversies in Obstetrical Ultrasound (Eastern Virginia Medical School), *Snowbird, Utah*. 16 credit hrs. CME Office, 804-446-6140.

March 10-17
7th Annual Wilmer Institute Current Concepts in Ophthalmology (Johns Hopkins), *Vail, Colorado*. 30 credit hrs. Fee, $475. CME Office, 301-955-2959.

March 11-14
Internal Medicine Seminar (Lloyd Noland Hospital), Disney World, *Lake Buena Vista, Florida*. CME Office, 205-783-5276.

March 13-14
13th Annual Symposium on Mental Health and the Law (University of Virginia Institute of Law, Psychiatry, Public Policy/Department Mental Health, Mental Retardation, Substance Abuse/Office of Virginia Attorney General), *Williamsburg*. Carolyn Englehard, 804-924-5435.

March 14-17
Pediatrics Seminar (Lloyd Noland Hospital), Disney World, *Lake Buena Vista, Florida*. CME Office, 205-783-5276.

March 15-17
Drugs, Behavior and the Brain: Advances in PET and SPECT Imaging (Johns Hopkins), *Baltimore*. 18 credit hrs. Fee, $440. CME Office, 301-955-6046.

March 19-21
Spectrum of Developmental Disabilities XII: Prematurity—Neuro-Developmental Assessment and Intervention Issues (Kennedy Fellows Ass'n/Kennedy Institute Handicapped Children/Society Developmental Pediatrics/Johns Hopkins), *Baltimore*. 20 credit hrs. Juliet M. Nutt, 301-550-9423.

March 23
Sleep Apnea (Eastern Virginia Medical School), *Norfolk*. CME Office, 804-446-6140.

March 24-25
Advanced Cardiac Life Support Provider Course (Fairfax Hospital), *Falls Church*. Fee, $200. Cathy Sarraf, 703-698-2572.

March 29-30
Diagnosis and Treatment of Neoplastic Disorders: Medical, Surgical and Radiotherapeutic Aspects (Johns Hopkins), *Baltimore*. 14.5 credit hrs. Fee, $250. CME Office, 301-955-2959.

March 30-April 1
Pediatrics 1990 (American Academy of Pediatrics), *Marco Island, Florida*. Suzanne Goheen, 312-981-7884.

April 1-4
Conference on AIDS (Johns Hopkins), *Baltimore*. Registration, 1-800-334-8644.

April 4
37th Annual Clinical Conference (Obici Hospital), *Suffolk*. George J. Carroll, MD, 804-934-4000.

April 6-8
Mammography: Current Concepts and Interpretation (Eastern Virginia Medical School), *Williamsburg*. CME Office, 804-446-6140.

April 6-8
Annual Ophthalmology Conference: Cornea and External Disease (Medical College of Virginia/VCU), *Williamsburg*. CME Office, 804-786-0494.

April 19-21
Annual Meeting, Virginia Society of Otolaryngology/Head and Neck Surgery, *Alexandria*. Donna Scott, 804-353-2721.

April 19-22
10th Edition, Clinical Electrocardiography: Basic Concepts and Interpretation (Eastern Virginia Medical School), *New Orleans, Louisiana*. CME Office, 804-446-6140.

April 20-22
12th Annual Emergency Medicine for the Primary Care Physician (Medical College of Virginia/VCU), *Williamsburg*. CME Office, 804-786-0494.

April 21
Regular meeting of the Medical Society of Virginia's Council, *Richmond*. James L. Moore, Jr., 804-353-2721.

April 24
Common Problems in Primary Care (Fairfax Hospital), *Falls Church*. Cathy Sarraf, 703-698-2572.

April 26-29
11th Edition, Practical Dermatology for the Primary Care Physician (Eastern Virginia Medical School), *New Orleans, Louisiana*. CME Office, 804-446-6140.

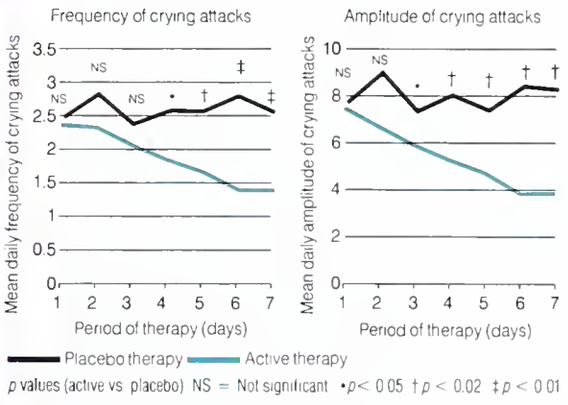
Family therapy for colic.

The excessive crying of colic puts a strain on the most loving family—and often on their physician as well. And whatever the cause of colic, one fact is clear:

Gas is often part of the colic problem.

New Phazyme Drops contains simethicone, which can safely break up gas and bring baby relief. That's why it can help whenever colic is a problem.

Significantly reduces crying of colicky infants.[1]



p values (active vs placebo) NS = Not significant •$p < 0.05$ †$p < 0.02$ ‡$p < 0.01$

Double-blind, randomized, placebo-controlled study

Priced 25% below the leading brand.

This significant price advantage will be particularly important to parents, since they may be relying on Phazyme Drops for up to three months. And it's naturally flavored—something else they'll appreciate.

NEW **Phazyme®** **Drops** (simethicone/antigas)

Helps you through the colic phase.

1. Kanwaljit SS, Jasbir KS. Simethicone in the management of infant colic. *Practitioner*. 1988;232:508

REED & CARNRICK
Piscataway, NJ 08855

©1989 Reed & Carnrick PZ24

FAMILY PRACTICE. A REWARDING EXPERIENCE IN ARMY MEDICINE.

The Army has more soldiers with families than ever before. So when you join the Army Medical Team as a Family Practitioner, expect to spend most of your time serving not only soldiers, but their spouses and children, too. What's more, you won't have to worry about the paperwork, malpractice insurance premiums, or the costs incurred in running a private practice.

Expect to work in a highly challenging and varied environment. Working with a team of highly trained professionals, you can receive assignments almost anywhere in the United States; the Army offers the largest system of comprehensive health care in the nation. Family Practice positions are also available overseas, in Germany and Korea.

The benefits package available to Army Family Practitioners is quite attractive. You'll receive 30 days paid vacation, opportunities to continue education and conduct research, a chance to travel, and reasonable work hours.

All in all, your Army Family Practice will be a rewarding experience. Not only for you, but for Army families, too. Talk to your Army Medical Department Counselor for more information.

ARMY HEALTH CARE TEAM
Federal Office Building
400 North 8th Street
PO Box 10167
Richmond VA 23240-0167
(804) 771-2354

ARMY MEDICINE. BE ALL YOU CAN BE.

MSV Phone Book

The Medical Society of Virginia
804-353-2721

American Medical Association
312-645-5000

Virginia State Board of Medicine
804-662-9908

Virginia Department of Health
804-786-3561

Medical Society of Virginia Impaired Physicians Program
804-353-2721

Medical Society of Virginia Review Organization
Preadmission: 800-553-1745;
Richmond 289-5336
General info: 804-289-5320

BC/BS Virginia Physicians Plan
800-552-2103
Richmond 355-8521

John P. Pearl & Associates
800-572-2211
Richmond 282-8900

Dodson Insurance Group
800-825-3760

Medical Protective Company
804-359-0036

Joint Underwriting Association
804-358-0909

Medicaid Provider Relations
800-552-8627
Richmond 786-6273

Medicare Provider Relations
Pars 804-330-6228
Nonpars 804-330-6237

AIDS Hotline
800-533-4148
Richmond 355-4428

ENJOY THE PRESTIGE OF THE MSV GOLD MASTERCARD WITH A 14.88% APR.

As a member of the Medical Society of Virginia, you're eligible for a very attractive rate on the MSV Gold MasterCard issued through Central Fidelity Bank.

With a fixed Annual Percentage Rate of just 14.88% and a reduced first year annual fee of only $15, you'll be able to pay off other cards and save on interest payments. That's an exciting prospect in itself. And when you add other preferred benefits like 24-Hour Travel Service and travel discounts, travel accident insurance and a package of medical, legal, car rental and pre-trip travel services... all at no additional cost, it's an offer you can't afford to pass up.

And, everytime you use the MSV Gold MasterCard, you're actually making a donation to the Society's Medical Student Loan Foundation.

So why not take advantage of this attractive membership service today. You'll enjoy the prestige it brings to you and the support it provides to Virginia's medical students.

Central Fidelity

Medical Society of Virginia

FOR SALE/LEASE

Prime Medical Facility

3800 Meadowdale Boulevard
(Chesterfield County)

★ 7,000 SQUARE FEET, FULLY EQUIPPED, READY TO OCCUPY

★ OUTSTANDING GENERAL PRACTICE/GROUP PRACTICE FACILITY

★ GROWTH AREA OF CHESTERFIELD COUNTY

CALL: SCOTT BOYERS, SCOTT WHITE or JIM MILBY

804/788-1000 ■ FAX 804/782-1145

Harrison & Bates
INCORPORATED

NEW AMERICA NETWORK

First National Bank Building ■ Suite 1800
823 E. Main St. ■ Richmond, VA 23219-3308
804/788-1000 ■ FAX 804/782-1145

National MULTIPLE LISTING

NOTE: This offering subject to errors, omissions, prior sale or withdrawal without notice.

NML 916

VIRGINIA MEDICAL CLASSIFIED

Virginia Medical classified ads accepted at the discretion of the Editor. Rates to Medical Society of Virginia members: $15 per insertion up to 50 words, 25¢ each additional word. To non-members: $30 per insertion up to 50 words, 25¢ each additional word. Deadline: 5th day of month prior to month of publication. Send to the Advertising Manager, 4205 Dover Road, Richmond VA 23221.

PRACTICE MARKETING—Customized services to increase patient satisfaction and activity. Practice analysis and profile, patient satisfaction audits, staff training, strategic planning, market demographics and referral development are among services offered to meet individual needs. Call (804) 748-7862. Market Impact, PO Box 1106, Chesterfield VA 23832.

VACATIONERS—Outdoor world membership resort privileges, coast to coast and Europe, for sale. Price negotiable. Contact Dr. Jerome Shapiro, 703-752-4480.

OB-GYN Physician, Shenandoah Valley–Four physician practice is seeking a physician to associate with them in an active OB-GYN practice utilizing a modern progressive community hospital. Enjoy the advantages of the University Medical Center within 25 miles. Live in the beautiful Shenandoah Valley and share a great call schedule that will allow you to take full advantage of the abundant opportunities offered in this area. Send CV to: OB-GYN Associates of Waynesboro, Inc., 428 S. Magnolia Avenue, Waynesboro VA 22980. Phone: 703-942-1214.

RICHMOND, Virginia—Seeking residency-trained physicians for full-time and part-time emergency department opportunities. Two facilities with a combined patient volume of 50,000 plus provides excellent medical and surgical back-up. Double coverage provided during peak periods. Excellent compensation and paid malpractice insurance. Benefit package available for full-time physicians. For more information contact: Betty Albrecht, Emergency Consultants, Inc., 2240 S. Airport Road, Room 40, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

PHYSICIANS NEEDED, Georgia—Family Practice, Internal Medicine, Oncology, Endocrinology, Neurosurgery, Neurology, General Surgery, Orthopedic Surgery. Group practice, solo or urgent care settings available through Charter Hospital network located in Macon and serving all Middle Georgia. Your practice will be located 60 miles south of Atlanta, in growing family-oriented community, where you can avoid traffic and enjoy a rewarding professional career. Please contact Stephen Wofford at 912-741-6283 for confidential consultation or write: Charter Northside, PO Box 4627, Macon GA 31208.

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85

AVAILABLE EXCLUSIVELY FROM

PALISADES PHARMACEUTICALS, INC.
219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

PHYSICIANS
Come Grow With Us

We are looking for physicians in:

*ORTHOPEDICS
*PEDIATRICS
*FAMILY PRACTICE
*EMERGENCY MEDICINE

Guaranteed salary, free office space, relocation expenses and malpractice assistance await your arrival to one of the best kept secrets in the State. Direct all inquiries to James Bryan, Administrator.

JEFFERSON MEMORIAL HOSPITAL

P. O. Box 1228 Charles Town, WV 25414

(304) 725-3411 Ext. 210

60 minutes from D.C.
15 minutes from Virginia, Maryland

WILLIAMSBURG VA—Unusual opportunity for BC/BE Family Practitioner to take over busy practice with two other BC Family Physicians. Send CV to: Cliff Henderson, MD, Williamsburg VA 23185; or call 1-804-220-2236 or 804-229-2546.

GRAND CAYMAN PARADISE—Luxury condo on Seven Mile Caribbean Beach, includes tennis court, bicycles, 2 pools, Jacuzzi, and Sunfish at the beach. 2-bedroom unit, last 2 weeks of August at $1000/week or $1800 both weeks. 3-bedroom unit, last 2 weeks of July, $1200/week or $2200 both weeks. Scuba, snorkel, sailing, fishing, golf all nearby. Dr. Jay Buston, 804-266-7613 or 804-272-7849.

FACULTY RESEARCH position available in the area of biochemistry of mucosal protection mechanism as applied to alimentary tract pathophysiology. Position requires MD and/or PhD with significant post-doctoral experience in biochemistry of alimentary tract secretions (especially mucin-lipid complex) and the ability to conduct independent research attracting extramural funding. Successful candidate will be acquainted with enzymology, chromatography (GLO, HPLO, TLO) as well as with RIA, ELISA, immunoblotting, and PAGE. Candidates should submit CV, statement of research interest and references to: R. W. McCallum, MD, Box 145, Charlottesville VA 22908. The University of Virginia is an affirmative action/equal opportunity employer.

HOLTER RECORDERS provided to physician's offices at no charge. Virginia Heart Institute's services includes scanning, analysis and interpretation of Holter 24-hour ambulatory recordings. Call 804-359-9265 or in Virginia 1-800-468-1030.

WINTERGREEN RENTAL—Cliffs Condominiums, two bedroom, two bath, overlooking entire Wintergreen village near top of the expert slope. Rates are substantially less than through Wintergreen's front desk. Call Thomas Shuttleworth at 804-431-3100 or write 2809 S. Lynnhaven Road, Virginia Beach VA 23452.

EMERGENCY DEPARTMENT staff physician being sought to join group of three providing coverage at client hospital located in Franklin, Virginia. Franklin is situated in historic southeast Virginia and surrounded by rolling hills and woods. Enjoy this beautiful countryside while being only 40 miles from the Norfolk/Newport News metro area and an hour and a half from the coast. This full-service facility serves a population base of 45,000. Annual ED volume 10,000. We are offering a generous rate of reimbursement plus ovcrage arrangement, occurrence malpractice coverage, allowance for CME, professional dues and relocation expenses. For complete details, contact Cathy Long, Spectrum Emergency Care, PO Box 27352, St. Louis MO 63141; 1-800-325-3982, ext. 3015.

APPRAISALS & SALES—The specialists in on-site practice valuations and transfers to physicians, hospitals and investors. Please contact: Ed Strogen, Fulton, Longshore & Asdsociates, Inc., 527 Plymouth Road, Suite 410, Plymouth Meeting PA 19462; 215-834-6780 or 1-800-346-8397.

FARMVILLE, Virginia—Seeking full-time and part-time physicians for hospital located 1 hour west of Richmond. Excellent compensation, full malpractice insurance coverage, and benefit package to full-time staff. Contact: Betty Albrecht, Emergency Consultants, Inc., 2240 S. Airport Road, Room 40, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

PRACTICE OPPORTUNITIES in Virginia—Excellent professional and lifestyle opportunity in southeastern Virginia. Sentara Health Plan, a staff model HMO, is seeking BE/BC Family Practice, Internal Medicine and Pediatric physicians. We are a subsidiary of Sentara Health System, the largest and most comprehensive health care network in Virginia, and are also affiliated with major teaching and community hospitals. Sentara Health Plan physicians practice at seven conveniently located Health Centers and admit patients to leading area hospitals. Outstanding cultural, educational and recreational activities. Competitive salary, benefits and incentive plan. Contact: Helen Clendenin, 22 Koger Executive Center, Suite 125, Norfolk, Virginia 23502 or call collect (804) 466-0712. An Equal Opportunity Employer.

VIRGINIA, Greater Richmond Area—Family physician or internist for office hospital practice. Excellent for ambulatory/primary care center. Salary for three months, then take over practice. Semi-retired physician for part-time flexible hours also needed. Inquiries held strictly confidential. Send CV and financial requirement to Va Med Box 131, 4205 Dover Road, Richmond VA 23221.

VASOTEC®

(ENALAPRIL MALEATE | MSD)

VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema.* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension. Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed, caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function.* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia. Elevated serum potassium (>5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions*.)

Surgery/Anesthesia. In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients.

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia. Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia. Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension, Patients on Diuretic Therapy. Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium. VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium. Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy – Category C. There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome: Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers. Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use. Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE. The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*), cardiac arrest, pulmonary embolism and infarction, rhythm disturbances, atrial fibrillation, palpitation.

Digestive: Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis, stomatitis.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Herpes zoster, urticaria, pruritus, alopecia, flushing, hyperhidrosis.

Special Senses: Blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgias/arthritis, myalgias, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema. Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension. In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC, but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension.* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions*.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment. The usual dose of enalapril is recommended for patients with a creatinine clearance > 30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤ 30 mL/min (serum creatinine > 3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure. VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions*.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects*.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Patients with Heart Failure and Renal Impairment or Hyponatremia. In patients with heart failure who have hyponatremia (serum sodium < 130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, *Heart Failure*, WARNINGS, and PRECAUTIONS, *Drug Interactions*.) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486

J9VS61(818)

MSD
MERCK SHARP & DOHME

For many
hypertensive patients

THERAPY THAT MAY BE AS SILENT AS HYPERTENSION ITSELF

VASOTEC is generally well tolerated and not characterized by certain undesirable effects associated with selected agents in other antihypertensive classes.

VASOTEC is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.
For a Brief Summary of Prescribing Information, please see the last page of this advertisement.

FOR MANY
HYPERTENSIVE PATIENTS
ONCE-A-DAY

VASOTEC®
(ENALAPRIL MALEATE | MSD)

UCSF LIBRARY
SERIALS DEPARTMENT
257 MEDICAL SCIENCES BLDG
SAN FRANCISCO CA 94143-0840

Copyright © 1990 by Merck & Co., Inc.

CURRENT
JNLS
WI
VI
799J

Virginia Medical
UCSF LIBRARY
Received on: 04-11-90

VIRGINIA MEDICAL

MAR
1990

UCSF LIBRARY
SERIALS DEPARTMENT
257 MEDICAL SCIENCES BLDG
SAN FRANCISCO CA 94143-0840

Guide to Precertification in Virginia

Medical Society of Virginia Members...

Five Great Ways to Protect Your Employees

Do something good for your employees. Offer them these five insurance plans at low group rates.

MSV Employee Protection Plans:

Term Life
- Up to $250,000 in benefits
- Family coverage available

$2,000,000 Catastrophic Major Medical
- Choice of deductible ($500, $1,000, $1,500 or $2,000)
- Pays 80% of first $25,000 of eligible expenses and 100% thereafter

24 Hour Accidental Death & Dismemberment
- Pays up to $500,000 for accidental loss of life, dismemberment or permanent total disability

Disability
- Up to $800 per month in benefits

In-Hospital Money
- Pays up to $150 per day in Benefits
- Double benefits for Cancer & Intensive Care

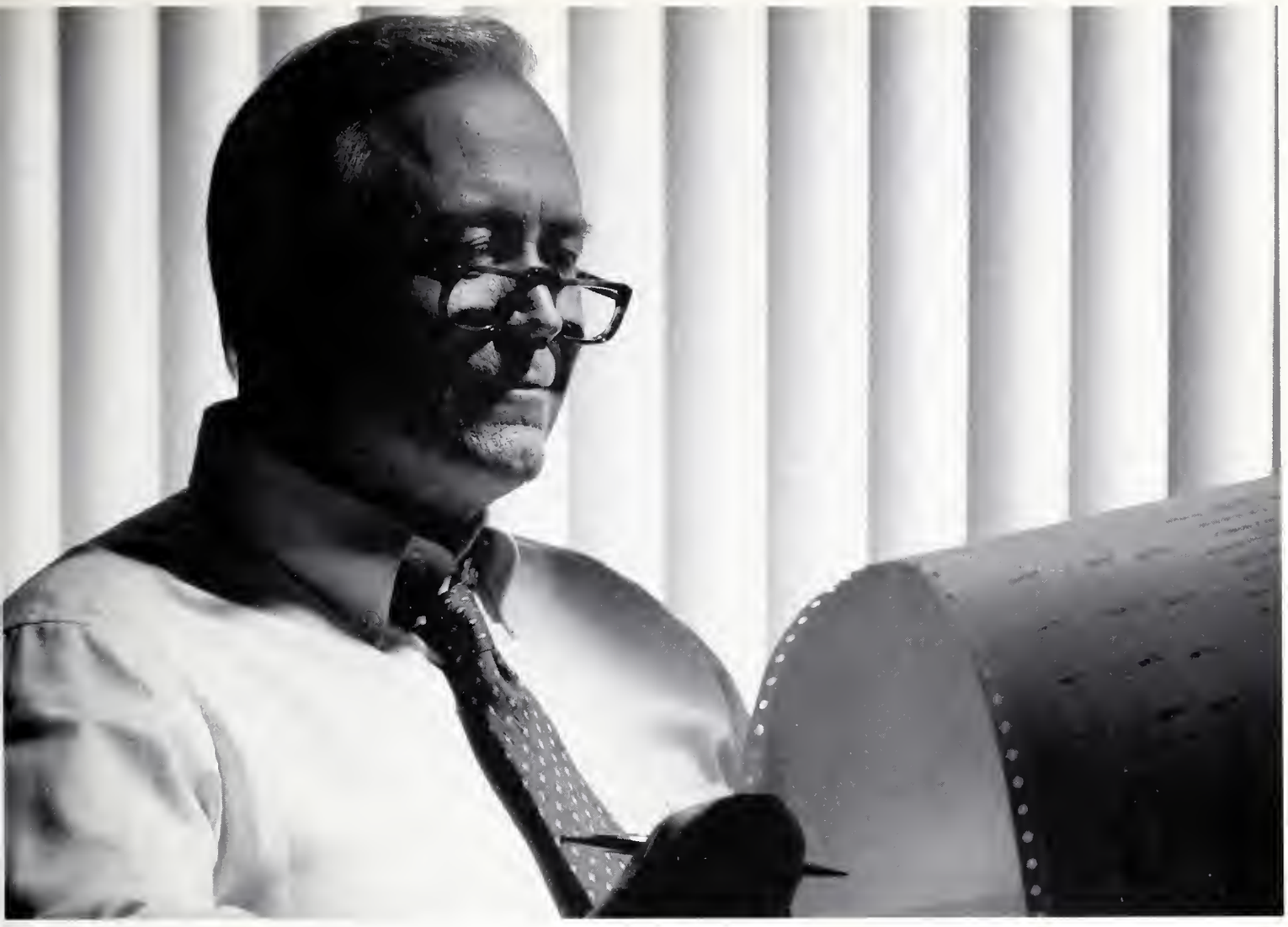
For more information regarding the Medical Society of Virginia's sponsored plans for your employees, including all costs, terms, limitations, conditions and exclusions, call the insurance administrator, **John P. Pearl & Associates, Ltd.**, on 804-282-9600 or Virginia toll-free 800-572-2211.

Administered By:

John P. Pearl & Associates, Ltd.
6620 W. Broad Street, Suite 300
Richmond, VA 23230-1724

Underwritten By:

Life Insurance Company of North America
and
Insurance Company of North America



Three financial reasons why practices choose the ACCLAIM™ Medical System

There are many compelling reasons to automate with the ACCLAIM Medical System. Here are three important benefits our customers have taken the time to write to us about:

1 Improved Cash Flow

"We have seen dramatic improvements in the efficiency of filing insurance claims and tracking accounts. We've also seen substantial improvement in our accounts receivable."

Susan Shaffer, Office Manager
Single Physician Practice

2 Increased Productivity

"The system is easy to use, straightforward in its commands and simplifies medical office management beyond belief."

Judy Greenburg, Office Manager
Four Physician Practice

3 Financial Control

"Sentient's ACCLAIM system has improved our collections by 100% and has provided reliable data on which to base practice management decisions."

Frank J. Mayo, M.D., Pulmonologist

Sentient Systems offers total solutions. Hardware (IBM® and compatible), software, installation, data conversion, training, support and service are a part of every system. We provide the highest quality medical system available today. Just ask our customers.

For a free consultation call Sentient at:

301-929-7600
800-247-9419

ACCLAIM is a trademark of Sentient Systems, Inc.
IBM is a registered trademark of International Business Machines Corporation.

I'm interested. Please...

☐ Rush me an information portfolio.
☐ Call to set up a free office analysis.

I plan to purchase within:

1 month ___ 2 months ___ 3-6 months ___

Practice Name

Address

City State Zip

Telephone Best time to call

Return to: Sentient Systems
10410 North Kensington Parkway
Kensington, MD 20895-2939

SENTIENT
SYSTEMS

THE MEDICAL COMPUTING LEADER

VIRGINIA MEDICAL

March 1990, Volume 117, Number 3

© 1990—The Medical Society of Virginia

ON THE COVER

105 **Precertification: Don't Let It Hurt Your Bottom Line**

107 **Virginia Medical's Guide to Precertification in Virginia**

Cover by Gary Brookins, Editorial Cartoonist, Richmond Times-Dispatch

MEDICINE

102 **Coronary Artery Bypass Surgery: Emerging Trends in Mortality**
Quentin Macmanus, Edward A. Lefrak, Alan M. Speir, Cleland C. Landolt, Nelson A. Burton, Bechara F. Aki, and Robert A. Albus

114 **Biliary Obstruction and Cholestasis in AIDS: Case Report**
Sheldon M. Markowitz, Thomas M. Kerkering, and Alfred S. Gervin

116 **Tinea Nigra Palmaris in Virginia: Case Report**
Samuel T. Selden

EDITORIALS

118 **Changing Perspectives: Coronary Artery Disease**
George W. Vetrovec

119 **Medical School Applications** E.L. Kendig, Jr.

119 **Great Communication** H.S. Campell

88 **Medibytes: Council's New Year Off to Good Start**

92 **New and Reinstated MSV Members**

120 **Obituary**

121 **Medical Society of Virginia Officers**

124 **Advice to Authors**

131 **Meetings about Medicine**

134 **Classified Advertisements**

135 **Directory of Advertisers**

136 **Who's Who**

Editor — Edwin L. Kendig, Jr., MD

Associate Editors — Richard G. Lester, MD; Duncan S. Owen, Jr., MD; John A. Owen, Jr., MD

Editorial Board — H. C. Alexander III, MD; Raymond S. Brown, MD; Henry S. Campell, MD; C. Barrie Cook, MD; Eloise C. Haun, MD; Walter Lawrence, Jr., MD; Lockhart B. McGuire, MD; Robert Edgar Mitchell, Jr., MD

Executive Editor — Ann Gray

Business Manager — James L. Moore, Jr.

DISCLAIMER: Advertisements in VIRGINIA MEDICAL for products, services, courses and symposia are published with a "buyer beware" understanding. The Publisher, the Editor and members of the Editorial Board do not imply warranty of products, nor endorsement of offered educational material.

VIRGINIA MEDICAL (ISSN 0146-3616) is the monthly publication of The Medical Society of Virginia. Second-class postage paid at Richmond, Virginia. Yearly subscription rate: $24 domestic, $30 foreign; single copies, $3. VIRGINIA MEDICAL does not hold itself responsible for statements made by any contributor. The publisher reserves the right to reject any advertisement. For information on the preparation of articles, write to the Executive Editor for "Advice to Authors," or call (804) 353-2721. POSTMASTER: Send address changes to VIRGINIA MEDICAL, 4205 Dover Road, Richmond VA 23221.

HERE'S ONE CASE OUR ADDICTION SPECIALISTS RARELY SEE.

You could probably say we've seen it all at the University Center for Addictive Behavior. Our patients range from the abuser to the severely addicted; from the adolescent to the older adult.

But even with our diverse caseload, you'll hardly ever see anyone being admitted to the hospital. Because we help patients overcome their problems without hospitalization, through comprehensive programs, which are conducted on an outpatient basis. Even chemical withdrawal can be done without the patient being admitted.

Of course, sometimes a patient will need to be hospitalized. We can arrange to do so on a short-term basis, until those patients are ready for one of UCAB's out-patient programs, exclusively staffed by MCV faculty.

If you know someone who needs addictions treatment, no matter how slight or how severe their problem, call UCAB. We're here to help stop their addiction. Case closed.

M C V
UCAB
HOSPITALS

Conveniently located in the West End. The Forum Executive Center, 10124 West Broad Street, Glen Allen, Virginia, (804) 662-7172

TRIP OF A LIFETIME RAFFLE

sponsored by

the Medical Society of Virginia and the MSV Auxiliary

Free trip for two to South America, airfare and hotel paid, to the lucky winner of the drawing on May 2, 1990.

TO ENTER YOUR NAME IN THE DRAWING:

1. Your check for your MSV dues 1989–1990 must be received at MSV headquarters no later than April 20, 1990. If you haven't paid your dues, dig out the statement sent to you in December or watch for the second billing going into the mail this month.

2. If you are married, your spouse must be a dues-paid member of the MSV Auxiliary as of April 20, 1990. Check with your spouse. Are her/his Auxiliary dues paid? If not, and you wish to pay them, send a separate check for $28 payable to the Medical Society of Virginia Auxiliary to Gail L. Tiesenga, MSVA Treasurer, 375 Middle Street, Portsmouth VA 23704.

Questions about MSV dues? Call Mrs. Nancy Renalds, 804-353-2721.
Questions about MSVA dues? Call Mrs. Tiesenga, 804-393-9453.

MEDIBYTES

NEWS FROM VA MED'S COMPUTER ROOM

COUNCIL'S NEW YEAR OFF TO GOOD START

A string of success stories brightened the agenda of the Medical Society of Virginia Council's first meeting of 1990 on January 20 in Richmond. The new MSV President, **Dr. William H. Barney**, presided.

Brightest and best of all was the news of the upturn in membership. Deunification triggered the turnaround, reported **Dr. Jeffrey W. Wilson**, chairman, Membership Committee, citing a big bunch of reinstatement requests and a surge of new members. All are listed by name on pages 94-101 of this issue, and Dr. Wilson forecast more to come when applications still outstanding are heard from...From the MSVRO via **Terry Dwyer**, exec director, came word of a small but significant success: Medicare precertification of certain surgical procedures has been modified to allow two working days after an emergency operation in which to obtain approval. The Council had worked on this sticky wicket, and so had the MSV and AMA Houses...All the signs of success are being exhibited by the Teen Health Forum in work under the auspices of the Auxiliary, **Mrs. Vivian Petty**, MSVA President, assured the councilors. Over 77 high schools over the state have expressed interest in participating in the event on March 20 in Richmond...In the solid success column, enter VaMPAC's reception for Virginia's legislators on the eve of the General Assembly's opening, said **Dr. Read F. McGehee, Jr.**, chairman elect, where a good time was had by a big crowd of legislators and physicians. Also solidly successful: VaMPAC's membership department, with a jump from 500 to 600 members. Another deunification bonus?...Two recent Medical Society of Virginia surveys/reports are rousing success stories, with lots of media coverage, all of it good, and respectful receptions by public health officials and the state legislature, counsel **Sandra Kramer** told the councilors. The one titled, "Problems and Solutions to Access to Obstetrical Care in Virginia" supported the medical community's perception that the problems of ob access are a result of malpractice costs, potential lawsuits, and the low rates and administrative hassles associated with reimbursement. Access to primary care was the subject of the second survey/report; by unanimous vote the councilors established an official

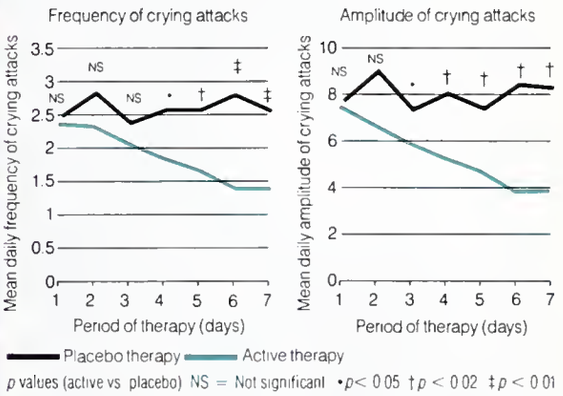
Family therapy for colic.

The excessive crying of colic puts a strain on the most loving family–and often on their physician as well. And whatever the cause of colic, one fact is clear:

Gas is often part of the colic problem.

New Phazyme Drops contains simethicone, which can safely break up gas and bring baby relief. That's why it can help whenever colic is a problem.

Significantly reduces crying of colicky infants.[1]



p values (active vs placebo) NS = Not significant •$p < 0.05$ †$p < 0.02$ ‡$p < 0.01$

Double-blind, randomized, placebo-controlled study

Priced 25% below the leading brand.

This significant price advantage will be particularly important to parents, since they may be relying on Phazyme Drops for up to three months. And it's naturally flavored–something else they'll appreciate.

NEW **Phazyme®** **Drops** (simethicone/antigas)

Helps you through the colic phase.

1. Kanwaljit SS, Jasbir KS. Simethicone in the management of infant colic *Practitioner.* 1988;232:508.

REED & CARNRICK
Piscataway, NJ 08855

©1989 Reed & Carnrick

PZ24

Trust. It's something you have to earn with every prescription you fill.

Every day, the pharmacists at Peoples Drug Stores fill prescriptions for customers of all ages. . . with every type of ailment. That's a big responsibility. . . both to you and to your patients.

But after over 80 years, we've established a level of trust and confidence that comes only from doing a good job. . . and doing it consistently. Prescription after prescription.

It's just another example of how Peoples Drug has served its customers with unmatched care and professionalism. Today, all our services reflect our continuing commitment to meeting the changing needs of *your* patients . . . who become *our* customers.

But everything we do begins with a vital ingredient called "trust."

PEOPLES DRUG®

the convenience you want...the SAVINGS you deserve

Peoples Pharmacists. Working with you to help your patients.

Present at Council's first meeting of the New Year were these new members: from left, Dr. Louis D. Parham, councilor, and Dr. Norman R. Edwards, vice councilor, 1st district; Dr. James A. Shield, Jr., councilor, and Dr. Lawrence E. Blanchard, III, vice councilor, 3rd district.

MSV position on the subject by endorsing that report's findings. Also in the area of primary care, the councilors adopted fourteen recommendations and a resolution from the Rural Health Committee, **Dr. Charles H. Crowder, Jr.,** chairman. They had to do with such problems as the supply of primary care physicians, inequities in reimbursement in rural areas, including low Medicaid fees, and protecting PCPs in solo practice from insurance prejudice and litigation problems...The Public Relations Committee, **Dr. William L. Harp,** chairman, was successful in its quest for an appropriation of $2,000 for the production of a public service announcement to be distributed statewide. On recommendation of the Executive Committee, Council okayed the request...To beef up the Society's membership recruitment and lobbying efforts, Dr. Barney announced, the Executive Committee wanted to solicit the part-time services of **Dr. James F. Ghaphery**, retired anesthesiologist and veteran contributor to countless MSV lobbying efforts. Was Council willing? You bet, responded the councilors. The solicitation was a success, and Dr. Ghaphery is now on staff as the Society's Field Representative. --A.G.

NEW AND REINSTATED MSV MEMBERS

A healthy upturn in Medical Society of Virginia membership was the instant response to MSV President William H. Barney's letter of November 21 announcing the end of four years of MSV/AMA unification. Receipts of applications of new memberships jumped from 58 for October-November to 78 for December-January, and as of February 1 a total of 262 lapsed members had requested reinstatement. The new members appear here as we usually publish them, according to component society of origin. The reinstated members are listed in the order in which their requests to rejoin were received.

Albemarle County Medical Society

David L. Bogdonoff, MD, General Surgery, 2100 Devonshire Road, Charlottesville VA 22901

R. J. Canterbury II, MD, Psychiatry/Neurology, Blue Ridge Hospital, 6 East Drawer D, Charlottesville VA 22901

Charles W. Gross, MD, Otolaryngology, Box 430, University of Virginia Health Sciences Center, Charlottesville VA 22908

Stuart S. Howards, MD, Urology, Box 422, University of Virginia Health Sciences Center, Charlottesville VA 22908

William F. Tompkins III, MD, Gastroenterology, 1100 East Jefferson Street, Charlottesville VA 22901

Alexandria Medical Society

Mark R. Fracasso, MD, Obstetrics/Gynecology, 4801 Kenmore Avenue, Alexandria VA 22304

Alleghany-Bath County Medical Society

James E. Ballou, MD, Internal Medicine, PO Drawer 547, Clifton Forge VA 24422

Mary Jane Luke, MD, Pediatric Cardiology, PO Box 351, Covington VA 24426

Arlington County Medical Society

Todd P. Berner, MD, Obstetrics/Gynecology, 2501 North Glebe Road, Arlington VA 22202

James C. McFalls, MD, Obstetrics/Gynecology, 1715 North George Mason Drive, Arlington VA 22205

Chesapeake Medical Society

Erik H. Kisa, MD, Emergency Medicine, 219-B 55th Street, Virginia Beach VA 23451

David A. Pitrolo, MD, Emergency Medicine, 524 Wickwood Drive, Chesapeake VA 23320

Lawrence E. Valentine, MD, Emergency Medicine, 7 Schooner Ridge, Kitty Hawk NC 27949

Bruce D. Waldholtz, MD, Gastroenterology, 300 Medical Parkway, Chesapeake VA 23320

Francis E. Watson, MD, Emergency Medicine, 513 Woodards Ford Road, Chesapeake VA 23320

Thomas V. Whelan, MD, Nephrology, 3033 Princess Anne Crescent, Chesapeake VA 23321

Danville-Pittsylvania Academy of Medicine

Bhushan H. Pandya, MD, Gastroenterology, 501 Rison Street, Danville VA 24541

Y. H. Charles Suh, MD, Cardiology, 115 South Main Street, Danville VA 24541

Fairfax County Medical Society

Robert A. Albus, MD, Cardiovascular/Thoracic Surgery, 3301 Woodburn Road, Annadale VA 22003

Allyson A. Askew, MD, Pediatric Surgery, 3301 Woodburn Road, Annandale VA 22003

John J. Basile, MD, Urology, 3299 Woodburn Road, Annandale VA 22003

Edward E. Eder, MD, Internal Medicine, 1015 Emerald Drive, Fairfax VA 22308

Ian H. Leibowitz, MD, Pediatric Gastroenterology, 3027 Javier Road, Fairfax VA 22031

Eveline B. Marguardt, MD, Obstetrics/Gynecology, 1800 Town Center Drive, Reston VA 22090
Mark D. Vickers, MD, Internal Medicine, 112 Elden Street, Herndon VA 22070

Fredericksburg Area Medical Society
Frank J. Durcan, MD, Obstetrics/Gynecology, 1701 Fall Hill Avenue, Frcdericksburg VA 22401

Hampton Medical Society
Paul W. Popish, MD, Pediatrics, 304 Marcella Road, Hampton VA 23666

Loudoun County Medical Society
Salvatore N. Amari, MD, Internal Medicine, 211 Gibson Street NW, Leesburg VA 22075
Russell H. Mitchell, MD, Dermatology, 823-J South King Street, Leesburg VA 22075

Lynchburg Academy of Medicine
David W. Frantz, MD, Thoracic Surgery, 2000 Tate Springs Road, Lynchburg VA 24501
Morris E. McCrary III, MD, Neurosurgery, 1922 Thomson Drive, Lynchburg VA 24501
Gerald S. Modjeska, MD, Occupational Medicine, 200 Howard Drive, Lynchburg VA 24503
William H. Van Dyke Jr., MD, Cardiology, 2215 Landover Place, Lynchburg VA 24501

Mid-Tidewater Medical Society
James R. Robusto, MD, Family Practice, PO Box 880, Urbanna VA 23175

Newport News Medical Society
Heather A. Argyle, MD, Gynecology, 606 Denbigh Boulevard, Newport News VA 23602
Laurel G. Weaver, MD, Anesthesiology, 60 Chowning Drive, Hampton VA 23664

Norfolk Academy of Medicine
Harlan L. Vingan, MD, Diagnostic Radiology, 6161 Kempsville Circle, Norfolk VA 23502

Northern Virginia Medical Society
Gregory P. Harris Sr., MD, Anesthesiology, 728 Treys Drive, Winchester VA 22601
Matthew Phillips, MD, Cardiology, 104 Selma Drive, Winchester VA 22601
Curtis A. Winter, MD, Obstetrics/Gynecology, 1330 Amherst Street, Winchester VA 22601

Patrick-Henry Medical Society
Myron E. Eller Jr., MD, Family Practice, 445 Commonwealth Boulevard, Martinsville VA 24112
Karl T. Wagner Jr., MD, Orthopedic Surgery. PO Box 3961, Martinsville VA 24115

Portsmouth Academy of Medicine
Hussein M. Aboulatta, MD, Cardiology, 3414 Bruin Drive, Chesapeake VA 23321
Stephen L. Carr, MD, Radiology, 1401 Walnut Hill Street, Norfolk VA 23508
Adrienne L. Coqueran, MD, Internal/Emergency Medicine, 921 Hanover Drive, Virginia Beach VA 23464
Lenard Jay Lexier, MD, Psychiatry, 1801 Portsmouth Boulevard, Portsmouth VA 23704
Michael E. Moreland, MD, Dermatology, 4041 Taylor Road, Chesapeake VA 23321

Prince William County Medical Society
Peter A. Bryce, MD, Obstetrics/Gynecology, 2296 Opitz Boulevard, Woodbridge VA 22191
Jared E. Florance, MD, Public Health/Preventive Medicine, 8806 Peabody Street, Manassas VA 22110
Ronald A. Hatcher, MD, Obstetrics/Gynecology, 2296 Opitz Boulevard, Woodbridge VA 22191

Richmond Academy of Medicine
Caroline P. Cella, MD, Family Practice, 2906 Forest Hill Avenue, Richmond VA 23225
H. H. Connor, MD, Pediatrics, 1601 Rolling Hills Drive, Richmond VA 23229
Michael F. S. Douglas, MD, Nephrology, PO Box 26467, Richmond VA 23261
Ruth L. Hillelson, MD, Plastic Surgery, 12801 Ironbridge Road, Chester VA 23831
Albert M. Jones Jr., MD, Physical Medicine/Rehabilitation, 1311 Palmyra Avenue, Richmond VA 23227
Marc R. Katz, MD, Cardiac Surgery, 7107 Jahnke Road, Richmond VA 23225
Michael K. Kyles, MD, Orthopedic Surgery, 700 West Grace Street, Richmond VA 23220
David W. Richardson, MD, Cardiology, Box 128, MCV Station, Richmond VA 23298

Rockingham County Medical Society
Glenn E. Deputy, MD, Neurology, 170 South Main Street, Harrisonburg VA 22801
Mark A. Kniss, MD, Family Practice, 1000 Chicago Avenue, Harrisonburg VA 22801
Wayne Weaver, MD, Family Practice, Route 1, Box 399, Mount Crawford VA 22841

Southwestern Virginia Medical Society
Larry A. Cowley, MD, Otolaryngology, 508 South Main Street, Blacksburg VA 24060

Tazewell County Medical Society
Surrinder K. Chopra, MD, Plastic/Reconstructive Surgery, 110 Huffard Drive, Bluefield VA 24605
Gregory J. Endres-Bercher, MD, Internal/Emergency Medicine, 215 Tower Street, Tazewell VA 24651
Muhammad R. Javed, MD, Cardiology, PO Box 896 Richlands VA 24641 *more*

Tri-County Medical Society

Ben B. Capati, MD, General Surgery, Southampton Medical Building, Franklin VA 23851

Haydeh Esmaili, MD, Psychiatry, 2470 Pruden Boulevard, Suffolk VA 23434

Jo Anne Gutliph, MD, Obstetrics/Gynecology, 707 Gittings Street, Suffolk VA 23434

Preston L. Judson, MD, Cardiology, 707 Gittings Street, Suffolk VA 23434

Stephen S. Marsh, MD, Family Practice, Smithfield Medical Clinic, Smithfield VA 23430

Virginia Beach Medical Society

Robert S. Juskevich, MD, Obstetrics/Gynecology, 1825 Colonial Medical Court, Virginia Beach VA 23454

Kris E. Kennedy, MD, Obstetrics/Gynecology, 1101 1st Colonial Road, Virginia Beach VA 23454

Martin G. O'Grady, MD, General/Vascular Surgery, PO Box 4159, Virginia Beach VA 23454

Williamsburg-James City County Medical Society

John H. Baker, MD, Obstetrics/Gynecology, 1115 Professional Drive, Williamsburg VA 23185

Richard G. Samaha, MD, Emergency Medicine, 111 Clarendon Court, Williamsburg VA 23185

David G. Teasley, MD, Plastic Surgery, 1315 Jamestown Road, Williamsburg VA 23185

Wise County Medical School

John L. Pellegrini, MD, General Surgery, Norton Community Hospital, Norton VA 24273

John M. Prince, Jr., MD, Internal/Pulmonary Medicine, 110 15th Street, #111, Norton VA 24273

Military

Raymond S. Crawford III, MD, General Surgery, 10708 Fred's Oak Court, Burke VA 22015

Residents

Claudia C. Bemis, MD, Psychiatry, 1035 Saint Ann's Drive, Richmond VA 23225

Steven T. Coulter, MD, Family Practice, 7401 Eastmoreland Road, Annadale VA 22003

REINSTATEMENTS

(in the order received)

Paul G. Rochmis, MD, Rheumatology, 3027 Javier Road, Fairfax VA 22031

Ann R. Rochmis, MD, Psychiatry, 3027 Javier Road, Fairfax VA 22031

David A. Ellington, MD, Family Practice, One East Preston Street, Lexington VA 24450

Robert M. Pickral, MD, Family Practice, One East Preston Street, Lexington VA 24450

Leslie W. Rose III, MD, Internal Medicine, 6912 Three Chopt Road, Richmond VA 23226

Walter E. Bundy III, MD, Ophthalmology, 400 Westhampton Station, Richmond VA 23226

Joel L. Koslow, MD, Internal Medicine, 4921 Seminary Road, #115, Alexandria VA 22311

Warren C. Hagood, MD, Family Practice, 2510 Fernwick Drive, South Boston VA 24592

Marvin E. Perkins, MD, Psychiatry, PO Box 126, Fincastle VA 24090

M. Pinson Neal Jr., MD, Diagnostic Radiology, 4607 Stratford Road, Richmond VA 23225

Srirani P. Chalasani, MD, Anesthesiology, 5312 Crossfield Road, Virginia Beach VA 23464

Albert L. Huber, MD, Allergy, 910 East High Street, Charlottesville VA 22901

Peter B. Blanchard, MD, Colon/Rectal Surgery, 1821 Old Dominion Parkway, #1, Virginia Beach VA 23454

Steven S. Warden, MD, Urological Surgery, 1120 First Colonial Road, #103, Virginia Beach VA 23454

Samuel B. Hunter, MD, Anatomic/Clinical Pathology, 1500 North 28th Street, Richmond VA 23223

James L. Dellinger, MD, Emergency Medicine, Route 1, Box 155, Dugspur VA 24325

F. A. Feddeman, MD, General Practice, 2 East Washington Street, Lexington VA 24450

S. Marc Krenytzky, MD, Pediatrics, 9394 Forestwood Lane, Manassas VA 22110

Clem Crossland, MD, General Practice, Box 7190, Suffolk VA 23437

William Nuckols, MD, Family Practice, 310 West Valley Street, Abingdon VA 24210

Anthony J. Buschi, MD, Diagnostic Radiology, 1403 Hilltop Road, Charlottesville VA 22903

N. G. Poulos, MD, General Surgery, 110 North Robinson Street, Richmond VA 23220

Jesse W. Cumbia, MD, Internal Medicine, 916-B East High Street, Charlottesville VA 22901

Lynn D. Lambert, MD, Pediatrics, 2400 Port Road, Harrisonburg VA 22801

William B. Cave, MD, Family Practice, PO Box 347, Madison VA 22727

James D. Dimmett, MD, Child Psychiatry, PO Box 253, Williamsburg VA 23187

Francis H. McMullan, MD, Dermatology, 1812 Monument Avenue, Richmond VA 23220

Charles R. Joseph, MD, Neurology, 1933 Thomson Drive, Lynchburg VA 24501

M. G. Wright III, MD, Pediatrics, 2301 Fall Hill Avenue, Fredericksburg VA 22401

Jae Juong Nam, MD, Otolaryngology, 6408-K Seven Corners Place, Falls Church VA 22044

Angela S. Navarre, MD, Child Psychiatry, 5024 Sylvan Road, Richmond VA 23225

Ronald A. Apter, MD, Cardiovascular Diseases, 6418 Crosswoods Drive, Falls Church VA 22044

Lawrence Cohen, MD, Orthopedic Surgery, 205 Lake Drive, Sterling VA 22170

Frank M. Johnson, MD, General Practice, 7533 Williamson Road, Roanoke VA 24019

more

We've been defending doctors since these were the state of the art.

Turn of the century trephine for cranial surgery and tonsillotome for removing tonsils.

These instruments were the best available at the turn of the century. So was our professional liability coverage for doctors. In fact, we pioneered the concept of professional protection in 1899 and have been providing this important service exclusively to doctors ever since.

You can be sure we'll always offer the most complete professional liability coverage you can carry. Plus the personal attention and claims prevention assistance you deserve.

For more information about Medical Protective coverage, contact your Medical Protective Company general agent.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Ted J. Pandak, David R. Fuller
Suite 205, 7275 Glen Forest Drive Richmond, Virginia 23226, (804) 285-4131

"Our Concern Be Peace Of Mind."

Theocritus, 230 B.C.

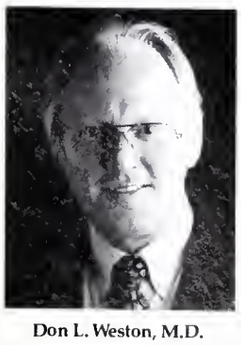
Charles M. Cooper, M.D.

Morgan E. Scott, M.D.

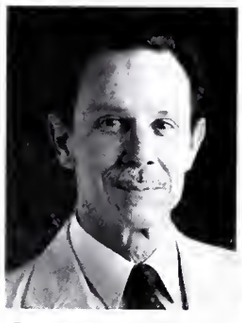
Neil P. Dubner, M.D.

Arthur E. Kelley, M.D.

Basil E. Roebuck, M.D.



Don L. Weston, M.D.



Orren LeRoyce Royal, M.D.

G. Paul Hlusko, M.D.

D. Wilfred Abse, M.D.

Ronald L. Myers, M.D.

Hal G. Gillespie, M.D.

Greek poet Theocritus said it. The eleven men who comprise the Active Medical Staff of Saint Albans Hospital practice it. Every day.

They combine years of study and experience to bring patients the best available care for emotional and psychological troubles. Their special interests cover the broadest spectrum of psychiatric treatment, resulting in both adult and adolescent programs for chemical dependency, eating disorders, phobias and anxieties, and pain management.

Our doctors lead a large group of professionals and volunteers who make compassion and expert care a way of life. Saint Albans. Today and for the past 74 years we are concerned, above all, with your peace of mind.

Saint Albans Psychiatric Hospital

Radford, Virginia (703) 639-2481

Chin-lin Cheng, MD, Emergency Medicine, 42 Euclid Avenue, Bristol VA 24201

William N. Hovland, MD, Internal Medicine, DePaul Medical Building, Norfolk VA 23508

William W. McClure, MD, Internal Medicine, 4715 North 15th Street, Arlington VA 22205

Daniel P. Hoback, MD, General Practice, PO Box 7236, Roanoke VA 24019

Rufus H. Gordon, MD, General Practice, 405 Oak Lane, South Boston VA 24592

Wilbur B. Carter Jr., MD, Family Practice, 1129 North Main Street, South Boston VA 24592

George Economo, MD, Diagnostic Radiology, 322 Linden Drive, Danville VA 24541

J. Leon Morris, MD, Diagnostic Radiology, PO Box 1603, Charlottesville VA 22902

Charles A. Stein, MD, Pediatrics, 633 Sunset Lane, #C, Culpeper VA 22701

R. M. Bell, MD, Abdominal Surgery, 38 Ridgeview Road, Staunton VA 24401

Andrew A. DelSordo, MD, Family Practice, 909 Hioaks Road, Richmond VA 23225

D. R. Williams, MD, Family Practice, 511 Boulevard, Salem VA 24153

Jamison K. Francis, MD, Dermatology, 14904 Jeff David Highway, Woodbridge VA 22191

Robert A. Orr, MD, General Practice, Box 510, Leesburg VA 22075

L. H. Phillips, MD, Neurology, Box 394, University of Virginia Health Sciences Center, Charlottesville VA 22908

William A. Blackman, MD, Internal Medicine, 2015 Tate Springs Road, Lynchburg VA 24501

Melvin Keim, MD, Family Practice, Staunton Medical Center, Staunton VA 24401

Michael L. Coates, MD, Family Practice, Box 414, University of Virginia, Charlottesville VA 22908

Hugh H. Wells, MD, Pediatrics, Roanoke Memorial Hospital, Box 13367, Roanoke VA 24033

Walter S. Barton, MD, General Practice, Box 718, Wytheville VA 24382

James I. Masloff, MD, Urological Surgery, 1011 East Jefferson Street, Charlottesville VA 22901

Paul R. Bauer, MD, Gynecology, 4037 Taylor Road, Chesapeake VA 23321

Richard P. Giannotto, MD, Orthopedic Surgery, Pembroke Four #210, Virginia Beach VA 23462

Robert W. Klink, MD, Obstetrics/Gynecology, PO Box 1290, Gloucester VA 23061

Richard Theis, MD, Family Practice, 502 Strawberry Plains Road, Williamsburg VA 23185

Henry D. Holland, MD, Psychiatry, 3900 Monument Avenue, Richmond VA 23230

James McKay, MD, Family Practice, 7103-B Jahnke Road, Richmond VA 23225

Leslie S. Kreisler, MD, Otolaryngology, 5855 Bremo Road, #406, Richmond VA 23226

Maurice Schiller, MD, Obstetrics/Gynecology, 6501 Loisdale Court, #608, Springfield VA 22150

Peter D. LeNard, MD, General Surgery, 1485 Chain Bridge Road, McLean VA 22101

I. C. Vernon Netto, MD, Urological Surgery, 2115 Executive Drive, #18, Hampton VA 23666

J. Michael Childress, MD, Pediatrics, 2300 Charles Street, Fredericksburg VA 22401

Stephen H. Martensen, MD, Orthopedic Surgery, Box 2698, Winchester VA 22601

Russell Handy, MD, Obstetrics/Gynecology, 3721 Barrington Bridge Place, Richmond VA 23233

Christine Hagan, MD, Family Practice, 7702 Parham Road, Richmond VA 23229

Theodore C. Andrew, MD, General Practice, PO Box 815, Hopewell VA 23860

Thomas James III, MD, Internal Medicine, 839 Poplar Hall Drive, Norfolk VA 23502

Stephen A. Schechner, MD, General Surgery, 321 Edwin Drive, #101, Virginia Beach VA 23462

Patricia D. Gonzales, MD, Pediatrics, 505 North Sixth Avenue, Hopewell VA 23860

Michael F. Ball Jr., MD, Endocrinology, 3299 Woodburn Road, Annandale VA 22003

Ilene Robeck, MD, Internal Medicine, 3299 Woodburn Road, Annandale VA 22003

Tom Skansi, MD, Radiology, 1821 Old Donation Parkway, Virginia Beach VA 23454

David O. Lewis, MD, Emergency Medicine, 1020 Turner Ashby Road, Martinsville VA 24112

Leslie S. Burt, MD, Pediatrics, 119 University Boulevard, #B, Harrisonburg VA 22801

D. L. Perry, MD, Family Practice, PO Box E, Timberville VA 22853

Alan M. Cohen, MD, Internal Medicine, 935 Redgate Avenue, Norfolk VA 23507

James Franklin Grim, MD, Neurology, 2029 Hunter Mill Road, Vienna VA 22181

Jay M. Levine, MD, Diagnostic Radiology, 1300 Westwood Avenue, Richmond VA 23227

L. Arnold Frederick, MD, Urological Surgery, 209 Clovelly Road, Richmond VA 23221

Vincente Castillo Jr., MD, Internal Medicine, PO Box 497, Stuart VA 24171

Jose D. Leoncio, MD, Internal Medicine, 1061 North George Washington Highway, Chesapeake VA 23323

Benjamin C. Sturgill, MD, Anatomic Pathology, Box 214 University of Virginia, Charlottesville VA 22908

Lawrence R. Burwell, MD, Cardiovascular Diseases, Box 158 University of Virginia, Charlottesville VA 22908

Manuel Galdos, MD, Obstetrics/Gynecology, 4000 West Mercury Boulevard, Hampton VA 23666

Hall Renfro Howard, MD, General Surgery, 1147-B Professional Drive, Williamsburg VA 23185

Richard A. Jackson, MD, Internal Medicine, PO Box 27888, Richmond VA 23260

Joseph S. Galeski III, MD, Internal Medicine, 7702 Parham Road, Richmond VA 23229

William E. Ramsey, MD, Internal Medicine, 2015 Tate Springs Road, Lynchburg VA 24501 *more*

Raymond G. Troiano, MD, Neurology, 1008 First Colonial Road #101, Virginia Beach VA 23454

Teofilo C. Mascarinas Jr., MD, Internal Medicine, 4551 Professional Circle, Virginia Beach VA 23455

Hamid M. Al-Abdulla, MD, Cardiovascular Diseases, 3604 Monument Avenue, Richmond VA 23230

H. H. Newsome, MD, General Surgery, Box 485, MCV Station, Richmond VA 23298

Walter B. Beverly, MD, Family Practice, 4753 John Scott Drive, Lynchburg VA 24503

Gil M. Ruiz, MD, Internal Medicine, 200 Little Falls Street, Falls Church VA 22046

P. Declan Burke, MD, Obstetrics/Gynecology, 5406 Sunset Lane, Culpeper VA 22701

Rager W. Jones, MD, Obstetrics/Gynecology, 1115 Professional Drive, Williamsburg VA 23185

John W. Harbison, MD, Neurology, Box 599, MCV Station, Richmond VA 23298

William G. Wilson, MD, Pediatrics, Box 386, University of Virginia Health Sciences Center, Charlottesville VA 22908

M. J. Lambert III, MD, General Surgery, 1100 East High Street, Charlottesville VA 22901

S. A. Howlett, MD, Gastroenterology, Professional Center, Waynesboro VA 22980

James T. Edwards Jr., MD, Family Practice, 12 Bruton Avenue, Newport News VA 23601

R. Bruce Redmon, MD, Otolaryngology, 633 Sunset Lane, Culpeper VA 22701

John Jay Payette, MD, Obstetrics/Gynecology, 610 Laurel Street, Culpeper VA 22701

William L. Rich III, MD, Ophthalmology, 6231 Leesburg Pike, Falls Church VA 22044

Robert G. Powell, MD, Family Practice, Route 6, Box 1850, Ashland VA 23005

David L. Harris, MD, Urological Surgery, Rappahannock Physicians Center, Kilmarnock VA 22482

Philip L. Minor, MD, Obstetrics/Gynecology, 3536 Grove Avenue, Richmond VA 23221

J. Grayson Grau, MD, Psychiatry, 732 Thimbleshoals Boulevard, Newport News VA 23606

Margaret S. Moore, MD, Neurology, 440 Hospital Drive, Warrenton VA 22186

Gregory M. Koons, MD, Obstetrics/Gynecology, 3905 Railroad Avenue, Fairfax VA 22030

Daniel G. Jenkins, MD, Obstetrics/Gynecology, 1115 Professional Drive, Williamsburg VA 23185

Wasfi Atiyeh, MD, Otolaryngology, 7601 Forest Avenue, #332, Richmond VA 23229

Donn S. Cobaugh, MD, Family Practice, 12801 Ironbridge Road, Chester VA 23831

G. V. Puster Jr., MD, Family Practice, 12801 Ironbridge Road, Chester VA 23831

Matthew O. Swartz, MD, Rheumatology, 9378-C Forestwood Lane, Manassas VA 22110

Thomas R. Stennett III, MD, Family Practice, 12801 Ironbridge Road, Chester VA 23831

Glen R. Rhodes, MD, Cardiovascular Surgery, 8301 Arlington Boulevard, #107, Fairfax VA 22081

Walter R. Zolkiwsky, MD, Family Practice, 207 East Holly Avenue, #214, Sterling VA 22170

B. N. Jones, MD, Emergency Medicine, 1802 Braeburn Drive, Salem VA 24153

Gordon D. Weirich, MD, Family Practice, Box 189, Weyers Cave VA 24486

Ronald N. Kroll, MD, Nephrology, 2505 Pocoshock Place, Richmond VA 23235

Jose K. Abrenio, MD, Anatomic/Clinical Pathology, Buchanan General Hospital, Grundy VA 24614

John Kattwinkel, MD, Neonatal-Perinatal Medicine, Box 386, University of Virginia Health Sciences Center, Charlottesville VA 22908

S. K. Paranthaman, MD, Pulmonary Diseases, 508 West Main Street, Appalachia VA 24216

Alfredo P. Soriano, MD, Internal Medicine, 610 East Liberty Street, Chesapeake VA 23324

Robert W. Allen Jr., MD, Neonatal-Perinatal Medicine, Route 4, Box 288, Troutville VA 24175

Linda S. Krell, MD, Neonatal-Perinatal Medicine, Roanoke Memorial Hospital, Roanoke VA 24033

Robert G. King Jr., MD, Ophthalmology, 2821 Parham Road, #104, Richmond VA 23294

Nellie D. Wright, MD, Pediatrics, 2475 Old Jonesboro Road, Bristol VA 24201

Patrick J. Bowen, MD, Urological Surgery, 3301 Woodburn Road, Annandale VA 22003

Robert K. Duley, MD, General Practice, 2913 Park Avenue, Richmond VA 23121

Paul R. McNeer, MD, Ophthalmology, 204 North Hamilton Street, Richmond VA 23221

Lloyd K. Kramer, MD, Neonatal-Perinatal Medicine, 3300 Gallows Road, Falls Church VA 22046

David L. Shank, MD, Family Practice, 1186 Portland Drive, Harrisonburg VA 22801

Richard L. Pietsch, MD, Ophthalmology, 820 East High Street, Charlottesville VA 22901

A. J. Taylor, MD, Urological Surgery, 500 Strawberry Place Road, Williamsburg VA 23185

Leon J. Brown Jr., MD, Family Practice, 101 Cowardin Avenue, #102, Richmond VA 23224

Albert J. Wasserman, MD, Internal Medicine, Box 565, MCV Station, Richmond VA 23298

Gregory J. Heyner, MD, Ophthalmology, 8133 Forest Hill Avenue, Richmond VA 23235

Joseph D. Brown III, MD, Family Practice, 102 Glenwood Drive, Williamsburg VA 23185

Bruce Butler Jr., MD, Hand Surgery, 5021 Seminary Road, #226, Alexandria VA 22311

Robert B. Eggleston, MD, Ophthalmology, 101 North Main Street, Harrisonburg VA 22801

Charles L. Johnston, MD, Hematology, Box 597, MCV Station, Richmond VA 23298

L. A. Lindquist, MD, General Surgery, 1045 Main Street, Danville VA 24541

Daryl H. Yoder, MD, Psychiatry, 2250 Murrell Road, #A, Lynchburg VA 24501

more

Do New Medical Malpractice Carriers Make You Nervous?

Some medical malpractice carriers offer a low price the first couple of years. After that, who knows?

We've been independent brokers for more than forty years and can offer competitive policies and premiums. We're not limited to an endorsed policy or exclusives required by many insurance carriers.

Find out about some **"A+"** companies who have established a track record. Save yourself some money.

We can advise you on the *best* policy for all your needs—from the *best* company at the *best* price. Frankly, we can handle all your professional and personal insurance needs, from office packages to auto coverages.

Call Clements and Company today for an "independent's approach" to buying medical malpractice insurance.

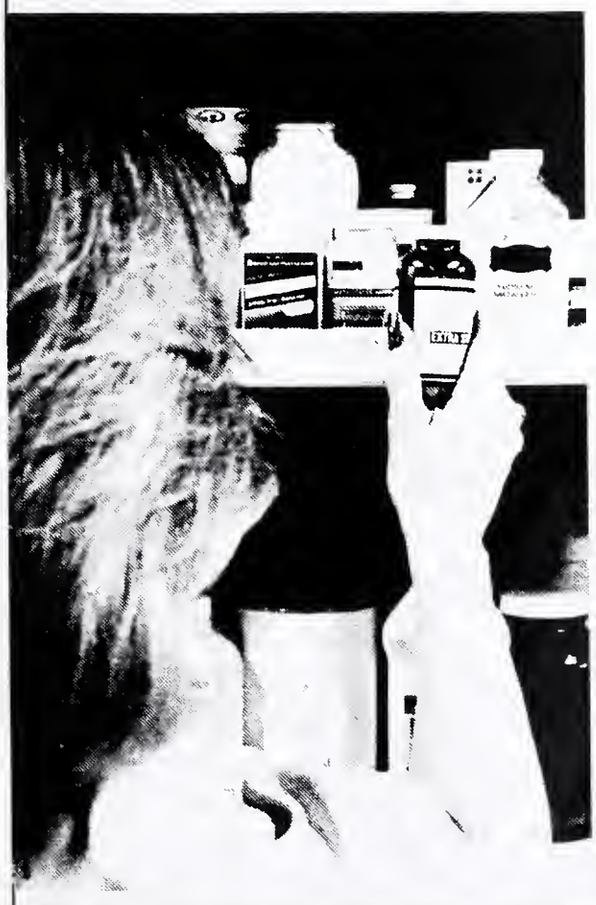
Clements and Company

Specialist in Medical Malpractice Insurance

Telephone: (202)872-0060 **Fax:** (202)466-9064

Telex: 64514 **Cable:** CLEMENTS/WASHINGTON

1730 K Street, NW, Suite 701, Washington, DC 20006



HEADACHE

THERE IS AN ALTERNATIVE

Headache is the most common disorder of modern man. It has been estimated that one out of three Americans suffers from severe headaches at one time or another.

The RICHMOND HEADACHE CENTER is a unique facility which specializes in the diagnosis and management of chronic and recurrent headaches.

The RICHMOND HEADACHE CENTER was founded by a group of practicing neurologists and clinical psychologists who recognized the need for a cooperative effort in treating chronic and recurrent headaches.

For more information, write or call .....

YES, please send me more information about RICHMOND HEADACHE CENTER.

NAME

ADDRESS

STATE

ZIP CODE PHONE

MAIL TO: RICHMOND HEADACHE CENTER
909 Hioaks Road, Suite I
Richmond, Virginia 23225

RICHMOND HEADACHE CENTER

909 Hioaks Road, Suite I
Richmond, Virginia 23225
Telephone (804) 320-3750

William F. Cavender, MD, Psychiatry, 7711 Lookout Court, Alexandria VA 22306

B. S. Malcolm, MD, Pediatrics, 105 Richeson Drive, Lynchburg VA 24501

James B. Troup, MD, Orthopedic Surgery, PO Box 2698, Winchester VA 22601

H. R. Kuo, MD, Family Practice, 616 George Washington Highway North, Chesapeake VA 23323

Barron H. Stillman, MD, Internal Medicine, 1821 Old Donation Parkway, #2, Virginia Beach VA 23454

Dieter H. M. Groschel, MD, Infectious Diseases, Box 168, University of Virginia Health Sciences Center, Charlottesville VA 22908

David C. Boxworth, MD, Internal Medicine, 321 Main Street, Newport News VA 23601

Gershon Silber, MD, Psychiatry, PO Box 728, Marion VA 24354

T. Remandaban, MD, Anesthesiology, 3839 Bosworth Drive, Roanoke VA 24014

Harold W. Markham, MD, Family Practice, 310 East Piedmont Street, Culpeper VA 22701

David Frenkel, MD, Psychiatry, 6073 Arlington Boulevard, Falls Church VA 22044

James E. Patterson, MD, Family Practice, 1154 Snider Street, Marion VA 24354

James P. King Jr., MD, Otolaryngology, 104 Doctors Park, Galax VA 24333

William P. Edmondson Jr., MD, Internal Medicine, 4805 Lauderdale Avenue, Virginia Beach VA 23455

Kenneth A. Powell, MD, Family Practice, PO Box 607, Appomattox VA 24522

Joseph F. Borzelleca Jr., MD, Obstetrics/Gynecology, 1520 Nottoway Avenue, Richmond VA 23227

Heeshin Kim, MD, Nephrology, 14904 Jeff David Highway, Woodbridge VA 22191

W. A. Heaton, MD, Hematology, 611 West Brambleton Avenue, Norfolk VA 23505

Brian J. Reynolds, MD, Psychiatry, 201 Park Street SE, Vienna VA 22180

Mitchell B. Miller, MD, Family Practice, 17760 Princess Anne Road, Virginia Beach VA 23456

John R. Morris III, MD, General Surgery, 1100 East High Street, Charlottesville VA 22901

Melvin L. Heiman, MD, Orthopedic Surgery, 300 East Valley Street, Abington VA 24210

W. Frederick Young, MD, Psychiatry, 14005 Steepleston Drive, Midlothian VA 23113

James S. Gregory, MD, Colon/Rectal Surgery, 7605 Forest Avenue, #308, Richmond VA 23229

Glenn P. Bidwell, MD, Family Practice, Family Practice Associates, Franklin VA 23851

Aurelius W. Brantley, MD, Family Practice, Family Practice Associates, Franklin VA 23851

C. L. Powell, MD, Urological Surgery, Family Practice Associates, Franklin VA 23851

William J. Watson, MD, Family Practice, 12507 Warwick Boulevard, Newport News VA 23606

Joseph Zanga, MD, Pediatrics, Box 514, MCV Station, Richmond VA 23298

James D. Aller, MD, Internal Medicine, 1139 East High Street, #105, Charlottesville VA 22901

Ramesh C. Luthra, MD, Urological Surgery, PO Box 1246, Norton VA 24273

Max Maizels, MD, Obstetrics/Gynecology, 7601 Forest Avenue, #336, Richmond VA 23292

Robert Bloom, MD, Internal Medicine, 3289 Woodburn Road, Annandale VA 22003

David M. Hudgins, MD, Family Practice, 250 Peppers Ferry Road, Christiansburg VA 24073

Richard W. Kesler, MD, Rheumatology, Box 386, University of Virginia Health Sciences Center, Charlottesville VA 22908

Dorothy G. Tompkins, MD, Pediatric Cardiology, Box 386 University of Virginia Health Sciences Center, Charlottesville VA 22908

G. Watson James III, MD, Hematology, PO Box 113, MCV Station, Richmond VA 23298

Nestor F. Natalio, MD, Family Practice, 3100 London Boulevard, Portsmouth VA 23707

Deborah L. Gofreed, MD, Pulmonary Diseases, 1400 South Joyce Street, Arlington VA 22202

Robert L. Castle, MD, Obstetrics/Gynecology, 2028 Opitz Boulevard, Woodbridge VA 22039

Wilson N. Cobbs, MD, Urological Surgery, 549 East Brambleton Avenue, Norfolk VA 23510

Herman F. Ziegler, MD, Radiology, Road 2, Box 515, Wytheville VA 24382

Frank Denaro, MD, Obstetrics/Gynecology, 4012 Raintree Road, #140, Chesapeake VA 23321

Garland Wampler, MD, General Practice, PO Box 2500, Staunton VA 24401

Charles J. Schleupner, MD, Internal Medicine, 6529 Fairway View Trail, Roanoke VA 24018

Bharat R. Patel, MD, Radiology, PO Box 3636, Radford VA 24141

E. D. Harris, MD, General Practice, 2409 Spinnaker Court, Virginia Beach VA 23451

Janet G. Hickman, MD, Dermatology, 2602 Langhorne Road, Lynchburg VA 24501

Paul T. Yoder, MD, Family Practice, 1047 Stuart Street, Harrisonburg VA 22801

Carol C. Hogg, MD, Public Health, PO Drawer C, Hampton VA 23669

Brian D. Buchanan, MD, Internal Medicine, 1700-D Whitfield Drive, Bedford VA 24523

Charles P. Winkler, MD, Radiology, 8952 Bellefonte Road, Richmond VA 23229

Douglas S. Richardson, MD, Dermatology, 21495 Ridgetop Circle, #204, Sterling VA 22170

Preston B. Mayson Jr., MD, Radiology, 322 Cassell Lane SW, Roanoke VA 24014

Jaime V Del-Pilar, MD, Emergency Medicine, 10569 Crestwood Drive, Manassas VA 22110

Charles W. Miller, MD, Orthopedic Surgery, 912 East High Street, Charlottesville VA 22901

Hoa Hong Ly, MD, Diagnostic Radiology, 7845 Oakwood Road, #105, Fairfax VA 22031

Scott A. Miller, MD, Internal Medicine, 850 Kempsville Road, Norfolk VA 23502

Susan E. Mackel, MD, Dermatology, 11835 Fishing Point Drive, Newport News VA 23606

D. Parker Moore Jr., MD, General Practice, 815 West Poythress Street, Hopewell VA 23860

Clemens E. Hallmann, MD, Family Practice, 1471 Johnston Willis Drive, Richmond VA 23235

Robert Lovinger, MD, Endocrinology, 2924 Brook Road, Richmond VA 23226

Gayle S. Vest, MD, Obstetrics/Gynecology, Route 1, Box 643, Big Stone Gap VA 24219

Steven Vest, MD, Gastroenterology, Route 1, Box 643, Big Stone Gap VA 24219

William G. Grover, MD, Emergency Medicine, Route 1, Box 200, Lowry VA 24570

Bennett A. Alford, MD, Radiology, Box 170, University of Virginia Health Sciences Center, Charlottesville VA 22908

B. Banian, MD, Cardiovascular Diseases, Box 432, Woodbridge VA 22194

Edwin T. Brownley, MD, Internal Medicine, 1413 Westbrook Avenue, Richmond VA 23227

Leonard L. Davis Jr., MD, General Practice, 5911 Portsmouth Boulevard, Portsmouth VA 23701

Ming S. Lee, MD, Pediatrics, 306 West Broadway, Hopewell VA 23860

James Robert Kistner, MD, Anesthesiology, Route 1, Box 691, Roanoke VA 24012

James W. Sublett Jr., MD, Anesthesiology, PO Box 2659, Lynchburg VA 24501

W. Woodrow Tanner, MD, Anesthesiology, 13908 Ladybank Court, Midlothian VA 23113

David Moga, MD, Orthopedic Surgery, 820 East High Street, Charlottesville VA 22901

Jack S. Garrison, MD, Family Practice, 669 Thalia Point Road, Virginia Beach VA 23452

Martha A. Carpenter, MD, Pediatric Cardiology, Box 386, University of Virginia Health Sciences Center, Charlottesville VA 22908

Neil Ira Stahl, MD, Internal Medicine, 1948 Opitz Boulevard, Woodbridge VA 22191

Raymond F. Ford, MD, Pediatrics, 1011 East Jefferson Street, Charlottesville VA 22901

A. G. Romero, MD, Family Practice, 6555 College Park Shopping Center, Virginia Beach VA 23464

Preston B. Mayson, MD, Radiology, 3322 Cassell Lane SW, Roanoke VA 24014

M. B. Wallace, MD, Family Practice, 800 Sunset Lane, #200, Culpeper VA 22701

Sarah A. John, MD, Emergency Medicine, 2857 Pine Spring Road, Falls Church VA 22042

Edward Jay Downs, MD, Emergency Medicine, 3417 Montgomery Place, Virginia Beach VA 23452

John D. Seibert, MD, Emergency Medicine, 641 Wickwood Drive, Chesapeake VA 23320

Elwood B. Boone Jr., MD, Urological Surgery, 209 Chickahominy Bluff Road, Richmond VA 23227

Lawrence J. Brunther, MD, General Practice, 11424 Vale Spring Drive, Oakton VA 22124

Karen B. White, MD, Internal Medicine, 9416 Park Hunt Court, Springfield VA 22153

Lawrence E. Zarchin, MD, Neurology, 3020 Haymaker Court, #400, Fairfax VA 22031

Brent R. Ain, MD, Orthopedic Surgery, 3650 Joseph Siewick Drive, Fairfax VA 22033

Alan D. Rogol, MD, Endocrinology, 685 Explorers Road, Charlottesville VA 22901

Richard Szucs, MD, Radiology, 3408-D Clubhouse Court, Richmond VA 23294

James A. Long, MD, Pulmonary Diseases, 13th at Magnolia, Waynesboro VA 22980

Raphael F. Guanzon, MD, General Practice, 704-A London Boulevard, Portsmouth VA 23704

John R. Lacey, MD, Internal Medicine, 336 Main Street, Newport News VA 23601

W. Kenneth Blaylock, MD, Dermatology, 3045 Stratford Road, Richmond VA 23225

Joseph P. Lemmer, MD, Rheumatology, 1802 Braeburn Drive, Salem VA 24153

Elliott R. Pearl, MD, Allergy/Immunology, 910 East High Street, Charlottesville VA 22901

T. Schildwachter, MD, Orthopedic Surgery, 914 East Jefferson Street, Charlottesville VA 22901

Syed S. Kazi, MD, Family Practice, 5001 West Village Green Drive, Midlothian VA 23112

Peter W. Brown, MD, General Surgery, 417 Libbie Avenue, Richmond VA 23226

Rolfe D. White, MD, Obstetrics/Gynecology, 1792 Greenward Quay, Virginia Beach VA 23454

David L. Charney, MD, Psychiatry, 414 North Union Street, Alexandria VA 22314

Wesley E. McEntire, MD, Psychiatry, 8923 Three Chopt Road, #302, Richmond VA 23229

Stephen F. Vaughan, MD, Family Practice, 2731 South Crater Road, Petersburg VA 23805

Young Lee, MD, General Practice, 603 South Sycamore Street, Petersburg VA 23803

Edward Jay Downs, MD, Emergency Medicine, 3417 Montgomery Place, Virginia Beach, VA 23452

Maria D. Kelly, MD, Radiation Oncology, 130 Turtle Creek Road #1, Charlottesville VA 22901

Munsey Stephen Wheby, MD, Hematology, Box 502, University of Virginia Health Sciences Center, Charlottesville VA 22908

James P. Wigand, MD, Internal Medicine, 7157 Jahnke Road, Richmond VA 23225

Brian M. Wasserman, MD, Internal Medicine, 7157 Jahnke Road, Richmond VA 23225

William Regelson, MD, Medical Oncology, Box 273, MCV Station, Richmond VA 23298

Y. Nabil Yakub, MD, Nephrology, 8316 Arlington Boulevard, Fairfax VA 22031 ■

VIRGINIA
MEDICAL
MARCH 1990

Coronary Artery Bypass Surgery: Emerging Trends in Mortality

Quentin Macmanus, MD, Edward A. Lefrak, MD, Alan M. Speir, MD, Cleland C. Landolt, MD, Nelson A. Burton, MD, Bechara F. Akl, MD, and Robert A. Albus, MD, *Falls Church, Virginia*

In a consecutive series of 4,697 patients undergoing coronary artery bypass surgery, these risk factors were found to be significant for increased postoperative mortality: age greater than 70, female sex, unstable angina, prior myocardial infarction, hypertension, diabetes mellitus, and ejection fraction less than .40. A comparison by year (1980–1988) revealed a steadily increasing incidence of these risk factors. Future analyses of coronary artery bypass mortality should include risk-factor stratification.

Following the introduction of coronary artery bypass surgery in 1968,[1] reports in the 1970s and early 1980s continued to document the decreasing risks of coronary artery bypass surgery.[2] Indeed, some institutions involved in the collaborative study in coronary artery surgery (CASS) reported overall operative mortality rates on patients operated between 1974 and 1979 of less than 1%.[2] More recently, however, many anecdotal and some documented reports have addressed a trend toward surgical revascularization for high-risk patients and medical management or transluminal angioplasty for low-risk patients, resulting in higher recent operative mortality rates.[3] To analyze the effects of this trend on current surgical mortality at our institution, we examined the mortality of coronary artery bypass surgery in the 1980s in relation to known or suspected risk factors.

From the Division of Cardiovascular Surgery, Fairfax Hospital, Falls Church VA 22046. Address correspondence to Dr. Macmanus at 3301 Woodburn Road, Suite 301, Annandale VA 22003.

Submitted 11-15-89.

Methods

Clinical and demographic data on all patients undergoing cardiac surgery at Fairfax Hospital, Falls Church, Virginia, are entered into a computerized data base using File Manager software and a DEC 11/24 computer. From January 1, 1980, through December 31, 1988, a total of 4,697 patients who had undergone primary, isolated coronary artery bypass surgery, including emergencies, were so entered. By definition this excluded patients undergoing redo surgery or patients having combined coronary artery bypass and cardiac valve procedures. Postoperative mortality, defined as inhospital mortality regardless of postoperative day, was recorded and analyzed in relation to suspected preoperative risk factors (Table 1) using standard chi-square analysis to compare the mortality of all patients in the series with a given risk factor to those without that risk factor. Following the identification of significant preoperative risk factors for increased surgical mortality, the incidence of these risk factors were analyzed by year.

Results

There were 3,482 males and 855 females whose age

and sex by year are noted in Figures 1 and 2. Overall operative mortality rate was 2.5%. Significant predictors of increased postoperative mortality are listed in Table 2. Not found to be significant were prior angioplasty, a history of cigarette smoking, or a family history of coronary artery disease.

The incidence by year of patients presenting with unstable or postmyocardial infarction angina, diabetes, and hypertension are shown in Figure 3A, and the incidence by year of female sex, ejection fraction less than .4, age greater than 70, and prior myocardial infarction are shown in Figure 3B. Particularly striking is the increasing incidence of hypertension, unstable angina, age greater than 70 and ejection fraction less than .4 in this surgical population. The trend toward increasing operative mortality is shown in Figure 4.

Table 1. Risk Factors Analyzed.

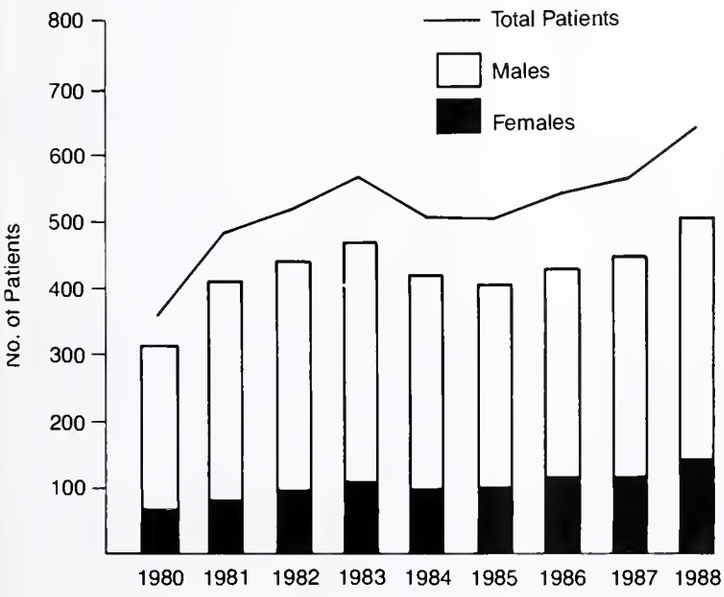
Prior angioplasty	Smoking history
Diabetes mellitus	Family history coronary artery disease
Unstable angina*	Age >70
Prior myocardial infarction	Ejection fraction <.4
Hypertension	Sex

* Defined as persistent or recurrent angina at rest despite maximal medical therapy. The vast majority of these patients are on intravenous nitrates preoperatively.

Table 2. Significant Risk Factors for Increased Operative Mortality

Variable	Overall Mortality (%)	p value
Diabetes mellitus	5.3	<.001
No diabetes mellitus	2.2	
Unstable angina	5.6	<.001
Not unstable	1.9	
Prior myocardial infarction	3.6	<.001
No prior myocardial infarction	1.7	
Hypertension	3.4	<.05
No hypertension	2.1	
Age >70	8.4	<.001
Age ≦70	1.9	
Ejection fraction .4	4.0	<.001
Ejection fraction .4	2.1	
Female sex	6.0	<.001
Male sex	1.9	

Fig. 1. Patient Population by Year and Sex.

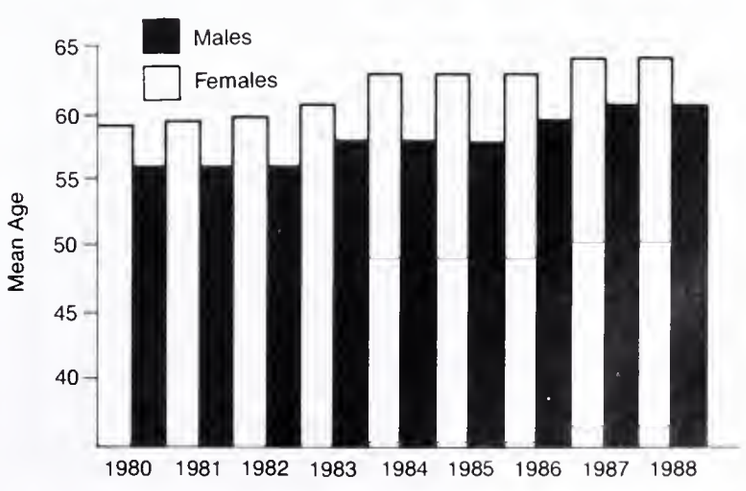


Discussion

A number of studies have documented the increased risk of coronary artery bypass surgery in the elderly, the clinically unstable, and those with impaired left ventricular function.[4–9] Females have a well-documented increase in risk, although this may be related to size more than sex.[10,11] Diabetes in some series has been associated with more extensive disease and increased operative risks independent of other factors.[12] Prior myocardial infarction was not assessed independently from left ventricular function and it is conceivable that prior myocardial infarction is a risk factor only as it relates to reduced ejection fraction. Hypertension is more common in the elderly and diabetics and its validity as an independent risk factor cannot be supported in this study.[12]

The increasing incidence of "high-risk" patients undergoing coronary artery bypass surgery found in this study is probably due to a number of factors, including the general aging of the population and the diminishing reluctance on the part of referring cardiologists to refer older, sicker patients for surgery. The fact that the "sickest" patients, e.g., those with severely diminished left ventricular function, may indeed represent a subgroup that has the most to gain from coronary artery bypass surgery is becoming well accepted.[13] Finally, the role of coronary angioplasty cannot be overemphasized. Davis and coworkers recently compared the mortality of coronary artery bypass surgery before and after the advent of angioplasty. They discovered the latter group to be significantly older with more prior myocardial infarctions, more co-morbidity, and a four-fold incidence of emergency surgery with an increased operative mortality rate.[14]

Fig. 2. Mean Age at Operation by Year.



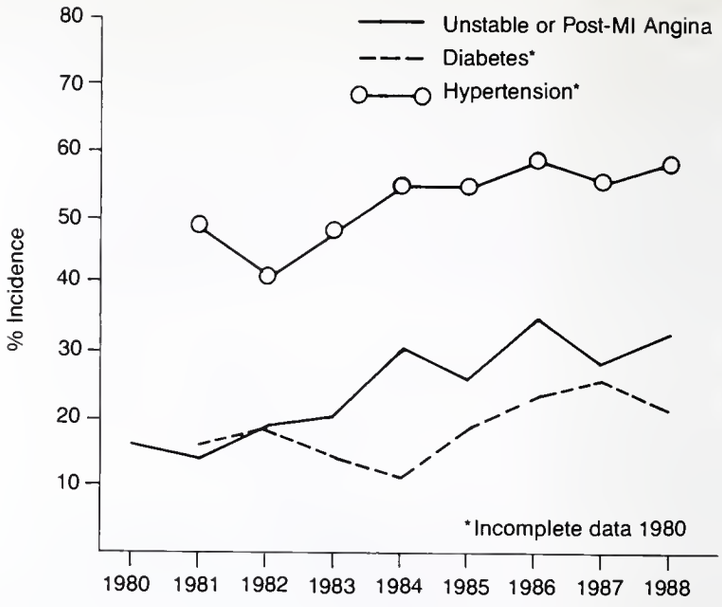
Conclusion

We conclude that patients undergoing coronary artery bypass surgery in the current era differ markedly from those operated upon in earlier years. Barring a dramatic, unforeseen breakthrough in the management of patients with coronary artery disease, we anticipate slowly increasing mortality associated with coronary artery bypass surgery. Earlier studies comparing medical and surgical therapy must be reconsidered in the light of a changing surgical population. Additionally, stratification by risk factors in analyzing coronary artery bypass mortality will become even more critical.

References

1. Favaloro RG: Saphenous vein graft in the surgical treatment of coronary artery disease: operative technique. J Thor CV Surg 1969;58:178-181
2. Kennedy JW, Kaiser GC, Fischer LD et al. Clinical and angiographic predictors of operative mortality from the collaborative study in coronary artery surgery (CASS). J Thorac Cardiovasc Surg 1981;63:793-801
3. Catliff RM, Hlatky MA, Mark DB et al. Randomized trials of coronary artery bypass surgery: impact on clinical practice at Duke University Medical Center. Circ (Suppl V) 1985;72:136-144
4. Gersh BJ, Kronmal RA, Schaff HV et al. Comparison of coronary artery bypass surgery and medical therapy in patients 65 years of age or older. N Engl J Med 1985; 313:217-224
5. Satler LF, Greene CE, Wallace RB, Rackley CE. Coronary artery disease in the elderly. Am J Cardiol 1989; 63:245-248
6. Alderman EL, Fischer LD, Litwin P et al. Results of coronary artery surgery in patients with poor left ventricular function (CASS). Circulation 1983;68:785-795
7. Naunheim KS, Fiore AC, Arango DC et al. Coronary artery bypass grafting for unstable angina pectoris: risk analysis. Ann Thorac Surg 1989;47:569-574
8. Myers WO, Davis K, Foster ED, Maynard C, Kaiser GC. Surgical survival in the coronary artery surgery study (CASS) registry. Ann Thorac Surg 1985;40:245-260
9. Hochberg MS, Parsonnet V, Gielchinsky I, Hussain SM: Coronary artery bypass grafting in patients with ejection fractions below 40%. Early and late results in 466 patients. J Thorac Cardiovasc Surg 1983;86:519-527
10. Douglas JS, King SB, Jones El et al. Reduced efficacy of coronary bypass surgery in women. Circulation 1981;64 (Suppl 11):11-16
11. Loop FD, Golding LR, Macmillan JP et al. Coronary surgery in women compared with men: analyses of risks and long-term results. J Amer Coll Cardiol 1983;1(2): 383-390
12. Salomon NW, Page US, Okies JE et al. Diabetes mellitus in coronary artery bypass: short-term risk and long-term prognosis. Thorac Cardiovasc Surg 1983;85:264-271
13. Killip T, Passamani EP, Davis K, and the CASS Principal Investigators and their Associates: Coronary artery surgery study (CASS): a randomized trial of coronary bypass surgery. Eight years follow-up and survival in patients with reduced ejection fraction. Circ 1985;72: 102-109
14. Davis PK, Parascandola SA, Miller CA et al. Mortality of coronary artery bypass grafting before and after the advent of angioplasty. Ann Thorac Surg 1989;47:493-498

Figs. 3A and 3B. Risk Factor Incidence by Year.



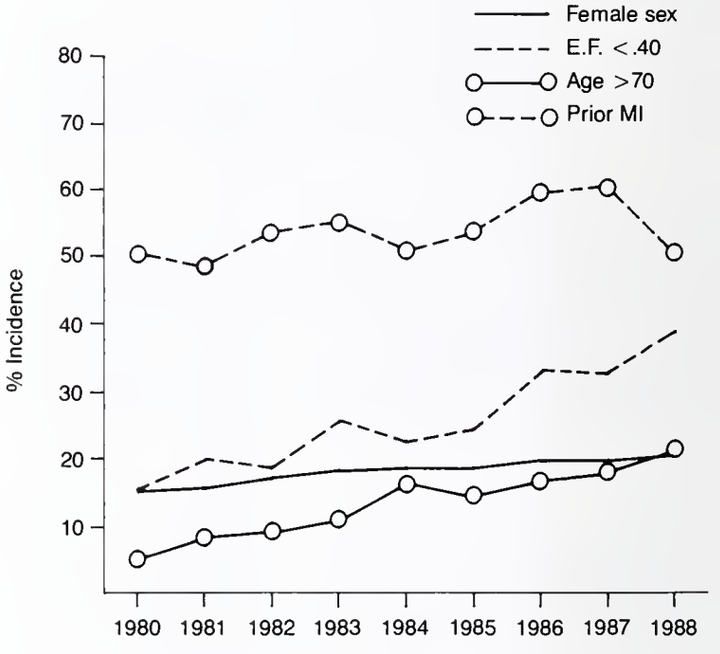
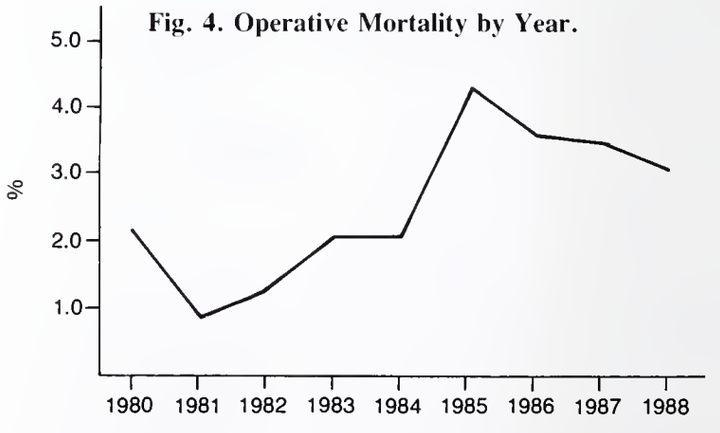


Fig. 4. Operative Mortality by Year.



Precertification:
Don't Let It Hurt Your Bottom Line

"In the final analysis, maintaining a smooth and efficient flow of information is the best way to meet precertification requirements—and to minimize the financial and patient-relation repercussions of *not* meeting them."

In the new reality of medical reimbursement, precertification is a must for most insurance companies—they'll pay for your patients' hospital stays and surgical procedures, on certain specific conditions. The precertification process has been adopted by insurers to control costs and eliminate "unnecessary" admissions. From the patients' perspective, there is nothing wrong with the process, because relatively few are denied coverage, while the process can reduce insurance costs to themselves or their employer.

However, precertification can have a significant impact on your practice's bottom line.

Don't Ignore Requirements

Your failure to obtain precertification—or to discharge a patient within the time period approved by the carrier without getting a "precertified" extension—can result in a lack of payment for the hospital admission or procedure. In that case, responsibility for payment then shifts to the patient.

The first problem that arises here is patient goodwill, which you may lose due to an oversight. The second problem is one of time and personnel management. Claims denied due to precertification problems increase the burden on your office collection process. Precious time, and the extra efforts of your billing staff, will be lost in billing the insurer, researching and challenging the denial, then rebilling the patient and explaining the reason for the denial. The results will show up on your bottom line; you will see increased staffing costs and a larger portion of outstanding accounts receivable.

Too often, the cost is larger and more directly felt. We have seen situations where physicians have kept patients in the hospital longer than the insurer approved and were left to write off their further charges because the patient could not pay. In one notable instance, a practice failed in its responsibility to obtain the necessary certifications and ended up paying the hospital charges for the "uncertified" days—to assuage an irate patient.

For medical practices, the basic problem with precertification, simply put, is that it is an information- and labor-intensive process. The troubles that develop usually derive from physicians' unfamiliarity with insurers' policies on hospital stays or their procedures for extending those stays. The chart published by VIRGINIA MEDICAL in this issue can help with this problem, but it is not a long-term solution, since it is subject to short-term change.

Therefore, because of the significant financial effects, practices must do more than review the chart; they must fully understand the general intent and specific points of insurer requirements, make sure their staff does likewise, and develop systems and routines to manage the process.

Gather the Information

Begin to manage the precertification process, rather than allowing it to manage you. Some preliminary legwork can be a real time- and money-saver when scheduling patients for surgery. Have your office manager or billing coordinator make a list of your major third-party reimbursers. Then have your staff contact those carriers and inquire as to their precertification requirements. VIRGINIA MEDICAL's chart provides your staff with the basic information you should request. Here are a few additional thoughts:

- Get answers that are as detailed as possible—exactly what procedures require precertification—and, when possible, have the carriers send the information in writing. Sending a letter to the carrier will usually spur a written reply; you can develop a form letter to standardize the process. Ask the carrier to put you on any regular mailing list it maintains for distributing precertification information and updates.
- Where possible, get the name of a specific individual to contact with

---

This article was developed by The Health Care Group © 1990. It was written by Patricia Salmon, vice president and senior consultant, and Julie Alderfer, practice management consultant. Address correspondence to The Health Care Group, Meetinghouse Business Center, 140 West Germantown Pike, Suite 200, Plymouth Meeting PA 19462.

your precertification requests and the name of an individual to contact with case-by-case questions. Then list all pertinent phone numbers in your files.

- Note where and when only the physician may request precertification—this will save the staff a phone call. Also note which carriers require that only the patient make the request.
- Detail the procedure to be followed when postoperative complications or other issues require treatment and inpatient time beyond that initially certified by the carrier.
- Determine under what circumstances precertification could be denied and work to avoid those situations.

Organize the Information

As the information flows in, create a reference board that lists all your major carriers' precertification requirements. We find that the best way to keep this information is on an eraseable-marker bulletin board, hung in the business office, or wherever the staffer responsible for precertification is located.

To be sure you have investigated all carriers' requirements, keep a list of those without precertification requirements adjacent to the board. This will probably be a short list. As patients introduce you to additional carriers, you should add those new carriers' information to the reference board.

Your staff should get into the habit of verifying the information with carriers quarterly. As the data changes, the reference board should be updated. As an alternative—or as a backup should the board be accidentally erased—a 3 × 5 card file can be developed. Each card would contain the complete set of precertification information for a single carrier; they would then be filed alphabetically.

Train the Staff

Whenever possible, assign one person the responsibility for coordinating precertification activities. The process and requirements are often so complicated that they necessitate consistent involvement by one person—a person who will keep abreast of each carrier's requirements and each patient's approval for treatment. This staffer's duties should also include surgical scheduling, because of the natural tie-in to precertification, and we recommend a medical background, an RN or LPN, for example.

However, each staff member should be made aware of the implications of not meeting precertification requirements—delays in surgery and in payments to the practice. Since you will probably see some patients with insurance that is not from one of the "major" carriers listed on your board, your staff must be trained to request and review patients' insurance cards, to identify precertification requirements before those patients are scheduled for procedures. Many patients do not realize that their insurance has such a requirement and will not be able to volunteer the information.

In most cases, it will be your receptionist who will have the best opportunity to get this information, when patients arrive for their first visit. However, the billing coordinator and the person staffing the "exit" desk should also be trained to check for the appropriate insurance and precertification information. In any case, that information should be in the patient's record when the precert/surgery coordinator receives the file and the doctor's directive to schedule a procedure.

If it is not currently being done in your office, the receptionist should make a copy of the front and back of all patient insurance cards and staple that copy to the chart jacket. This information should be verified and updated on a regular basis. Then, if your practice is computerized, a special notation that precertification requirements exist should be made on the patient's insurance screen. If your practice is not computerized, the notation should be made on the patient's ledger card.

Tracking/Updating Certification

We recommend to practices that they develop a simple form for the precertification coordinator to complete when requesting and receiving clearance for a patient's procedure. This will assure that the correct information has been obtained. The form should be kept in the patient's chart and should include:

- patient's name
- date precertification was requested
- diagnosis
- procedure to be performed
- number of hospital days approved
- precertification approval code
- insurance staffer who approved admission
- hospital staffer who took precert information at time procedure was scheduled
- whether additional hospital days were requested, why, and if approved

Conclusion: Information Is Key

In the final analysis, maintaining a smooth and efficient flow of information is the best way to meet precertification requirements—and to minimize the financial and patient-relation repercussions of *not* meeting them.

The physician plays a key role in this process: first, by identifying precertification as an important issue for the practice; second, by working with the staff to establish a formal precertification routine; third, by recording complete and specific information on diagnoses, procedures, and developing complications—which allows the staff to carry out its responsibilities quickly and effectively.

Perhaps though, the most important part of this information loop—where the process begins and ends—is the individual patient. You must educate your patients on the purpose and widespread use of precertification requirements, and on the potential dollar-impact for the patient. Your effort to educate patients can help prevent problems if they feel they are being discharged too soon. Such education can be accomplished through your patient-education materials, your practice newsletter, or during pre-surgical counseling.

VIRGINIA MEDICAL'S

Guide to Precertification in Virginia

Virginia's hospitals racked up an estimated 720,000 admissions in 1989,[1] and every last one of those patients was admitted by a Virginia physician. Until recently, arranging for a patient's hospitalization in Virginia was no big deal. In the normal circumstance all a doctor had to do was call up the hospital and reserve a bed.

But in 1984 precertification of hospital admissions was imposed in Virginia, and since then doctors have not only had to work up their patients, a clinical task they love, but they have had to work up proof that the patient's hospital admission is necessary, an assignment that went instantly to the top of the doctors' regulatory hate list.

Precertification, or preauthorization, as some call it, is a manifestation of the brave new world of managed medical care. Its intended goal is 1) to discipline medical costs so that 2) insurance premiums, already at unseemly levels, don't break everybody's budget. What better place to implement it than in the physician's office, where any unnecessary hospital admissions can be nipped in the bud?

The goal is worthy, the approach problematic:

Physicians have not been used to having their treatment plans nipped, in the bud or anywhere else. And they have not been accustomed to shuffling umpteen papers to prove the need for a patient's hospitalization. And they were absolutely appalled when they were presented with the laborious, time-consuming precertification process of pleading each case, one by one, according to the variable criteria of myriad plans/carriers/review agencies.

In the beginning, five years ago, the variables were indeed a nightmare. One plan didn't know what the other was doing. Subscribers' identification cards were mazes of fine print. Phone lines seemed infernally busy or didn't answer.

Today, thanks to national standards, VIRGINIA MEDICAL's chart demonstrates a much simpler, almost codified, system.

Simpler, yes, but simple it still isn't. Despite valiant efforts by plans and carriers and reviewers to beef up their answering powers with more phones and savvy personnel, the physician may still encounter road blocks—lots of ON HOLD, lots of delays because the screening person isn't sufficiently knowledgeable, lots of non-callbacks, lots of patient demographics required. Doctors perceive such hangups as barriers to patient care, and barriers to patient care profoundly disturb even the most fervent advocate of managed medicine. A Richmond physician who is such an advocate says that if he thinks something is really wrong with the way his precertification request is handled, he fires off a letter of complaint to the State Insurance Commissioner. It helps him a lot to get it off his chest. More importantly, he hopes it will lead to improvements in the system. But whether it does or not, this, he believes, is the bottom line:

"Preadmission certification is a fact of life, and precertified ambulatory surgery is on the way in. We've got to learn how to operate the system."

The plans/carriers/review agencies who graciously contributed data to this chart precertify most of the hospital admissions in Virginia. Their information is subject to change, but this bird's-eye view of certification, assembled for the first time by VIRGINIA MEDICAL, may serve as a lasting context for the Virginia physician as he goes about getting his patients into the hospital.

—ANN GRAY

1. Estimate based on projected figures, Virginia Hospital Association, January 24, 1990

Name/Address of Plan	**Ætna Life and Casualty 2809 Emerywood Parkway Richmond VA 23260**	**Blue Cross Blue Shield of Virginia 2015 Staples Mill Road PO Box 27401 Richmond VA 23279**
Reviewer Name/Address	Same as above	Blue Cross Blue Shield of Virginia Health Care Management PO Box C32104 Richmond VA 23261-2104
Certification Phone Number	See member's ID card	If patient's contract ID specifies "Admission Review Required," call 804-359-7277 or I-800-242-7277.
What procedures require precertification for medical indications?	See ID card	Preauthorization not required, but subscriber may request it for high-dollar services, transplant, growth hormones, potentially cosmetic/investigative procedure, etc.
What procedures require precertification for setting?	See ID card	Contract specific. Most group contracts require review of all hospitalizations.
Who may request certification?	Patient, MD office, hospital admissions	Physician, patient, hospital
Who handles certification requests?	Physician reviewer, RN	RNs, physicians
What data will be asked for?	Patient: name, address, birthdate, SS#, ID#, relationship to insured person, company name. Physician: name, address, phone, tax ID#. Procedure: location of service, admission date, estimated length of stay, treatment plan.	For Admission Review Program: diagnosis, treatment, lab values, history, other medical conditions. All others: diagnosis, functional problems, indications for surgery, procedures/ services required.
When must preadmission certification be obtained?	14 days prior to elective admission (or as soon as admission is scheduled)	Before hospital admission. Maternity admission in last trimester.
How about an emergency?	Within 48 business hrs after admission	Within 48 hours
Who issues denials?	Usually by physician, sometimes RN	Nurse reviewer, medical director
How can a denial be appealed?	Request reconsideration. Case then reviewed by another physician reviewer or medical director.	Submit written request for appeal with medical documentation
If MD violates denial, what is penalty?	Partial or complete denial may occur	Claim can be denied
To ask question or make complaint	Ætna toll free # on ID card	Donna Campbell, RN 804-342-2668
Medical director	Richard Bondi, MD	Richardson Grinnan, MD, Chief Healthcare Officer

CHAMPUS	Choice Health Plan 8550 Lee Highway Fairfax VA 22031	George Washington University Health Plan 1901 Pennsylvania Avenue NW Washington DC 20006	Group Health Association 4301 Connecticut Avenue Washington DC 20008	HMO Virginia 2220 Edward Holland Drive Richmond VA 23261	Kaiser Permanente Medical Program of the Mid-Atlantic States 4200 Wisconsin Avenue NW Washington DC 20016
Medical Society of Virginia Review Organization PO Box K70 Richmond VA 23288	Same as above	Same as above	Robert Younes, MD, Regional Medical Director, GHA 5109 Leesburg Pike Falls Church VA 22041	Same as above	Same as above
1-800-533-1745, 804-289-5336 Fax: 804-289-5395	703-849-9772	202-416-0477	703-824-3005	Richmond: 804-355-6327 Tri-Cities: 1-800-533-5592 Tidewater: 1-800-533-5592	1-800-765-2262
Tonsillectomy/adenoidectomy (single or combined), cholecystectomy, hysterectomy, C-section	All hospital care, surgeries, procedures outside MD office, services by non-participating providers	Mammoplasty (reduction, augmentation), septoplasty/rhinoplasty, temporal mandibular joint syndrome surgery, nevus removal, varicose vein surgery, circumcision, blepharoplasty	All procedures	All procedures done in hospital or ambulatory surgery setting	All care rendered by Kaiser Permanente physicians
None. All considered inpatient.	All procedures	Inguinal hernia repair, cataract extraction, oral surgery, endoscopy, arthroscopy	All procedures	All procedures	NA
Physician or designated representative	Primary care physician, staff, specialist	Physician, nurse, secretary, office workers	Physician or staff	Physician or staff	NA
MSVRO RNs, physician reviewers	RNs supported by medical director	RN. May refer to medical director.	Primary care physician	PCP must approve all admissions	NA
Patient: name, address, birthdate, relationship to insured; insured's name, address, SS#. Physician: license #. Procedure: diagnosis, hospital, admission date, unstable medical condition(s) affecting surgery.	Patient: name, birth date, ID #. Procedure: diagnosis, IP or OP, location of service, admission/procedure date, supporting clinical data (prefer written).	Patient: name, home/work phone, birthdate, Plan medical record #. Physician: name, phone, specialty. procedure: diagnosis, location of service, procedure date, anesthesia, referral # if available.	Patient: name, ID#. Physician: name. Procedure: diagnosis, IP or OP, admission date.	Patient: name, ID #, name of PCP. Physician: name. Procedure: diagnosis, location of service, admission date.	NA
72 hours prior for phone or fax, 10 days prior for mail-in. Certification valid for 60 days from issue.	Sufficiently prior to admission for second opinion if needed	At least 1 week prior to procedure	One week	At least 24 hours. OB patients within 30 days of due date.	NA
Precertification required. Can be faxed prior to procedure or phoned in within 2 working days of procedure.	PCP must authorize before services rendered. In life-threatening situation, PCP or member must notify Plan within 24 working hrs.	Call before procedure if possible. Or retrospective authorization may be given.	Within 24 hours	As soon as possible	Notify Kaiser Permanente at time of treatment (1-800-765-2262). Patient must file claim.
MSVRO physician reviewers	Medical director	Medical director	Primary care physician, regional medical director, claims processing unit	PCP and Plan director	Kaiser Permanente
MD or patient can ask for immediate reconsideration of denial. Case thoroughly re-reviewed by another physician.	By phoning/writing medical director	MD may contact medical director for reconsideration of denial	Write Claims Management Unit 4301 Connecticut Avenue Washington DC 20008	Formal grievance process (see manual)	Patient appeals by procedure outlined in handbook
Claim may be denied	Claim may be denied	Plan reimburses only precertified procedures, except emergencies	Claim will be denied	Payment will be denied	NA
Cynthia Pyne, RN 804-289-5320	Member services, 1-800-537-5096	Christina Bridgeport, RN 202-416-0477	Robert P. Younes, MD 703-824-3005	Richmond: 804-358-9088 Tri-Cities: 1-800-421-1883 Tidewater: 1-800-421-1883	1-800-765-2262
Eugene F. Poutasse, MD	Edward J. Smith, MD	Neeraj Kanwal, MD	Turner Bledsoe, MD	W. Richard Stubbs, MD	Martin Bauman, MD

Name/Address of Plan	**Medicaid** **600 East Broad Street** **Richmond VA 23219**	**Medicare**	**Partners Health Plan of the Mid-Atlantic** **8550 Lee Highway** **Fairfax VA 22031**	**Southern Health Services** **4222 Cox Road** **Glen Allen VA 23061**
Reviewer Name/Address	State Department of Medical Assistance Services	Medical Society of Virginia Review Organization PO Box K70 Richmond VA 23288	Same as above	Same as above
Certification Phone Number	804-786-3820	1-800-533-1745, 804-289-5336 Fax: 804-289-5395	1-800-468-7730 or 703-876-2855	804-270-9200 Tri-Cities: 804-748-9240 Nights/weekends: 804-342-0409
What procedures require precertification for medical indications?	Elective surgery, i.e., morbid obesity, virginal breast hypertrophy	Cataract extractions, carotid endarterectomies, cholecystectomy, major joint replacement, coronary artery bypass with graft, percutaneous transluminal coronary angioplasty (PTCA), laminectomy for herniated lumbar discs (L2-S1), hysterectomy (abdominal and vaginal), inguinal hernia, prostatectomy	All hospital care, surgeries, procedures outside MD office, services by non-participating providers	Procedures/services listed in *Evidence of Coverage* and *Physician Office Manual*. Call for details.
What procedures require precertification for setting?	See Medicaid physician's manual: App B, page 1 thru 6	Cataract extractions, inguinal hernia	All procedures	See above.
Who may request certification?	Physician	Physician or designated representative	Primary care physician or specialist	Physician
Who handles certification requests?	Physician reviewer	MSVRO RNs, physician reviewers	RNs	RNs
What data will be asked for?	Patient: name, address, birthdate, sex, Medicaid #. Physician: name, address, phone, Medicaid provider #. Procedure: location, IP or OP, date of procedure, diagnosis, procedure, medical indications.	Patient: name, address, birthdate, sex, Medicare #. Physician/surgical assistant: name, address, license #. Procedure: diagnosis, IP or OP, location of service, admission date, indications, unstable medical condition(s).	Patient: name, birthdate, ID#. Procedure: diagnosis, IP or OP, location of service, admission/procedure date, supporting clinical data (prefer written).	Patient: name, ID#. Physician: name. Procedure: Date admission, date service, hospital/facility, diagnosis, procedure/ treatment/services.
When must preadmission certification be obtained?	Minimum 48 hrs prior to surgery	72 hours prior for phone or fax, 10 days prior for mail-in. Certification valid 60 days from issue.	Sufficiently prior for review/second opinion (recommend 7–10 days before services rendered)	Prior to procedure
How about an emergency?	Not necessary. Emergencies covered if justified by documentation.	Precertification required. Can be faxed prior to procedure or phoned in within 2 working days of procedure.	PCP must authorize. If life-threatening situation, PCP must notify Plan within 24 working hours.	Within 24 hours, not including weekends and holidays
Who issues denials?	Physician reviewer	MSVRO physician reviewers	Medical director	RNs. All denials reviewed by nurse manager and medical director.
How can a denial be appealed?	Physician may request reconsideration. Case given to another physician reviewer for 2nd evaluation.	MD or patient can ask for immediate reconsideration of denial. Case thoroughly re-reviewed by another physician.	By phoning/writing medical director	Phone nurse manager or medical director. Written appeal to Utilization Review Committee.
If MD violates denial, what is penalty?	Payment withheld or adjusted	Claim subject to denial	Claim may be denied	Payment will be denied
To ask question or make complaint	Helpline for billing/general info: Richmond area, 804-786-6273 Other areas, 1-800-552-8627	Cynthia Pyne, RN 804-289-5320	Member services, 1-800-537-5096	Member services: 804-270-7800 Provider services: 804-747-3700
Medical director	Robert L. Wood, MD	Eugene F. Poutasse, MD	Edward J. Smith, MD	Mark A. H. Smith, Jr., MD

Lewis-Gale Clinic

Virginia's Largest Multi-Specialty Medical Group Practice

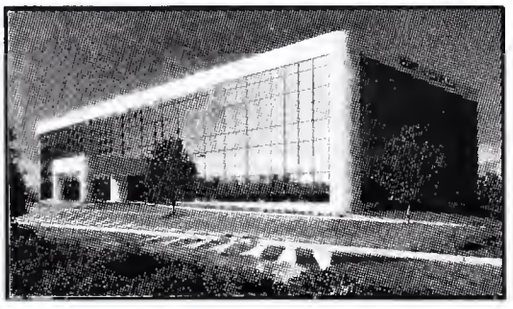
Full Medicare Participation

772-3400

1802 Braeburn Drive, Salem
Adjacent to Lewis-Gale Hospital
772-3400

Business Office
Medicare **772-3760**
All other accounts
(See top of Clinic
monthly statement)

Satellite Family Practice Clinics
BACK CREEK 989-0757
FINCASTLE 992-2110
FORT LEWIS 380-4300
NEW CASTLE 342-7677
WEST SALEM 387-0441



4910 Valley View Blvd., Roanoke
At Valley View Mall
265-1600

ALLERGY & IMMUNOLOGY
Paul F. White, M.D.

ANESTHESIOLOGY
Leigh O. Atkinson, M.D.
George P. Baron, M.D.
Daniel C. Summerlin, Jr., M.D.
Joe F. Clark, M.D.
George S. Coury, M.D.
Gennard T. Lanzara, M.D.

ARTHRITIS & RHEUMATOLOGY INTERNAL MEDICINE
William M. Blaylock, M.D.
Joseph P. Lemmer, M.D.

CARDIOLOGY
David S. Miller, II, M.D.
Jacob P. Neathawk, Jr., M.D.
J. Phillip Bushkar, M.D.
William B. Rutherford, Jr., M.D.

COUNSELING/PSYCHOLOGY
J. Steven Strosnider, LPC
Samuel B. Rogers, Jr., Ph.D.
Bruce A. Sellers, Psy.D.
John Heil, D.A.
Robert M. Lanahan, Psy.D

DERMATOLOGY
Gary P. Gross, M.D.
Larry W. Patton, M.D.

EMERGENCY MEDICINE
Benjamin N. Jones, M.D.
John S. Jeremiah, M.D.
John M. Garvin, M.D.
Robert O. McGuffin, M.D.
Thomas Gary Parrish, M.D.
Roger D. Tims, M.D.
Thomas M. Phillips, M.D.

EXECUTIVE HEALTH MEDICINE
Lucian Y. Grove, Jr., M.D.

FAMILY PRACTICE
Allen M. Clague, M.D.
Keith C. Edmunds, M.D.
William C. Crow, Jr., M.D.
Samuel N. Smith, M.D.
Howard W. Lebow, M.D.
Wilson H. Coulter, M.D.
John F. Daugherty, M.D.
Clarke B. Andrews, M.D.
Marc G. Nevin, M.D.
Ella M. Dickinson, M.D.
Kevin C. Kelleher, M.D.
David A. Keilman, M.D.
Gregory L. Still, M.D.
James W. Robinson, M.D.
Charles E. Lamb, M.D.
Clement B. Binnings, Jr., M.D.
William C. Greer, M.D.
Victor H. Bell, M.D.

FERTILITY & REPRODUCTIVE HEALTH
James Freeman Holman, M.D.

GASTROENTEROLOGY & ENDOSCOPY/ INTERNAL MEDICINE
George H. Wall, M.D.
Joseph L. Nelson, III, M.D.
M. Jonathan Bern, M.D.
Douglas W. Kirtley, M.D.

HEMATOLOGY & ONCOLOGY/ INTERNAL MEDICINE
Paul D. Richards, M.D.
William A. Fintel, M.D.

INFECTIOUS DISEASE/ INTERNAL MEDICINE
Douglas D. Blevins, M.D.

INTERNAL MEDICINE
Michael J. Moore, M.D.
E. Blackford Noland, Jr., M.D.
Myron S. Levey, M.D.
Daniel M. Camden, M.D.
Lucian Y. Grove, Jr., M.D.

NEUROLOGY/ NEURO-OPHTHALMOLOGY
Edward A. Waybright, M.D.
Timothy L. Hormel, M.D.
Gary J. Harpold, M.D.

NEUROSURGERY
Charles H. Anderson, Jr., M.D.

OBSTETRICS & GYNECOLOGY
Carl B. Harms, M.D.
James A. Kelly, M.D.
George W. Maxymiv, M.D.
Debra H. Clapp, M.D.
Mark W. Gustafson, M.D.

OCCUPATIONAL MEDICINE
E. Wilson Watts, Jr., M.D.
Darrell F. Powledge, M.D.
Benjamin N. Jones, M.D.

OPHTHALMOLOGY
J. Stanwood Till, M.D.
Donna L. Maxfield, M.D.

ORTHOPAEDIC SURGERY
Richard H. Fisher, M.D.
Alonzo H. Myers, Jr., M.D.
S. Curtiss Mull, M.D.
Bertram Spetzler, M.D.
John P. Clarke, M.D.
Brian A. Torre, M.D.
James W. McLeod, M.D.

OTOLARYNGOLOGY
J. Bruce Hagadorn, M.D.
Tu A. Tran, M.D.

PATHOLOGY
Anthony V. Torre, M.D.

PEDIATRICS
F. Joseph Duckwall, M.D.
William J. Kagey, M.D.
Luthur A. Beazley, III, M.D.
Dawn Elizabeth Forbes, M.D.
Lee Anne Steffe, M.D.

PLASTIC RECONSTRUCTIVE & HAND SURGERY
Robert F. Roth, M.D.
Carol A. Reichel, M.D.

PULMONARY DISEASES/ INTERNAL MEDICINE
James A. Witten, Jr., M.D.
Nelson B. Greene, M.D.

RADIOLOGY & NUCLEAR MEDICINE
Clyde F. Lloyd, M.D.
William A. Cassada, Jr., M.D.
J. William Barnard, M.D.
John M. Mathis, M.D.
Mary Ella Zelenik, M.D.
Placido H. DeGuzman, M.D.
Bruce C. Banning, Jr., M.D.

GENERAL THORACIC & VASCULAR SURGERY
William L. Sibley, III, M.D.
George R. Shumate, M.D.
A. Reif Kessler, M.D.

UROLOGY
T.S.R. Ward, M.D.
Jeffrey S. Jones, M.D.

Accredited by the
Accreditation Association
for Ambulatory Health Care

Biliary Obstruction and Cholestasis in AIDS: Case Report

Sheldon M. Markowitz, MD,
Thomas M. Kerkering, MD, and
Alfred S. Gervin, MD, *Richmond*

PERSONS infected with the human immunodeficiency virus type 1 (HIV-1) frequently develop gastrointestinal symptoms and signs, including weight loss and diarrhea. A number of recent reports have documented the involvement of the biliary tract in the acquired immunodeficiency syndrome (AIDS).[1–7] Most patients have presented with a clinical, biochemical and radiological picture of biliary obstruction, usually associated with varying degrees of stenosis of the intrahepatic and extrahepatic biliary systems. Gallstones universally have been absent. Cytomegalovirus, cryptosporidia and other as yet unidentified pathogens have been proposed as likely etiologic agents, leading to edema, inflammation and fibrosis of bile ducts. We describe herein a previously unrecognized cause of biliary tract obstruction and cholestasis in a patient with AIDS.

Case Report

A 32-year-old female with a diagnosis of AIDS had been treated previously for pulmonary and disseminated cryptococcosis and disseminated *Mycobacterium avium-intracellulare* infection. She had received approximately 2 grams of amphotericin B and was being maintained on weekly amphotericin B and daily rifabutin, clofazimine, ethambutol and isoniazid. She was hospitalized with a one-week history of nausea, vomiting, fever and right upper quadrant abdominal pain. On physical examination, her temperature was 38.6°C orally. Epigastric and right upper quadrant abdominal tenderness and Murphy's sign were present. The gallbladder was palpable. Laboratory examination revealed the following: total bilirubin, 0.2 mg/dl; alkaline phosphatase, 368 U/L (normal, 20-125); lactate dehydrogenase, 192 U/L (normal, 100-125); gamma-glutamyl-transpeptidase, 170 U/L (normal, 0-45), alanine aminotransferase, 36 U/L (normal, 0-50); serum creatinine, 1 mg/dl; and serum amylase, 145 U/L (normal, 16-108). Two-dimensional ultrasonography of the right upper quadrant revealed a distended, thin-walled gallbladder with "sludge" but no gallstones (Fig. 1A).

Because of progressive and intractable symptoms, the patient underwent a right upper quadrant abdominal exploration two days after admission. At operation, the gallbladder was noted to be markedly distended. The common duct was normal in size without obstruction. However, the cystic duct was dilated and found to be obstructed by multiple enlarged periductal lymph nodes. Multiple nodes were biopsied for histopathology and cultures and the obstructing nodes excised. A cholecystojejunostomy was performed.

The patient's symptoms abated rapidly following surgery, while the biochemical pattern of biliary obstruction worsened in the immediate postoperative period, only to improve later. Histologic examination revealed the virtual replacement of normal nodal architecture by histiocytes containing organisms compatible with cryptococci (Fig. 1B). No viral inclusions were seen. *Cryptococcus neoformans* was isolated from cultures of the lymph nodes.

One month following surgery, repeat two-dimensional ultrasonography of the right upper abdominal quadrant revealed a slightly distended gallbladder. On examination, abdominal tenderness was absent and her gallbladder was no longer palpable. Liver function studies were markedly improved. Three months following surgery, the patient developed *Pneumocystis carinii* pneumonia and acute myocarditis and later died of a recalcitrant ventricular arrhythmia. No autopsy was obtained.

Discussion

Abdominal symptoms and signs in patients with AIDS may result from multiple visceral organ involvement by opportunistic pathogens and by various tumors.[6] A change in bowel habits, weight loss and diarrhea are common, occurring in 50% or more of HIV-infected individuals.[2] The incidence of abdominal pain, particularly as an early manifestation of HIV infection, is not known, but abdominal pain has been associated with pathology at all levels of the gastrointestinal tract, including esophagitis, gastroduodenitis, enterocolitis, proctitis, hepatitis and hepatosplenomegaly, pancreatitis, peritonitis, retroperitoneal lymphadenopathy, gastrointestinal bleeding, and intestinal perforation.[2,8] At least 26 patients with AIDS and significant gallbladder disease have been reported since 1983.[1–7] Typically, patients presented with symptoms, signs and biochemical evidence of cholestasis and biliary obstruction, often with marked elevation of the alkaline phosphatase and lesser degrees of elevation of aminotransferases. Over half had normal serum bilirubin levels, including all patients reported by Schneiderman.[6] Gallstones were absent in all in-

From the Departments of Medicine (Drs. Markowitz and Kerkering) and Surgery (Dr. Gervin), Veterans Administration Medical Center and Medical College of Virginia/Virginia Commonwealth University. Address correspondence to Dr. Markowitz at the Infectious Diseases Section (111-C), Veterans Administration Medical Center, 1201 Broad Rock Boulevard, Richmond, VA 23249.

Submitted 5-11-89.

stances, although there was presence of sludge in a few. Characteristic findings in most patients were structural abnormalities of intrahepatic and extrahepatic bile ducts associated with infection by cytomegalovirus, cryptospordia, *Candida albicans* and *M avium-intracellulare*.[1–7] In a recent report of AIDS cholangiopathy,[7] six of 26 patients with clinical and laboratory evidence of biliary tract disease were found to have normal retrograde cholangiograms and no histopathologic abnormalities on biopsy of the duodenal papilla. *M avium-intracellulare* was isolated from the blood cultures of one patient and the liver biopsy of another, but for these patients, as for all those previously described, no causal relationship was established.

The clinical presentation of this patient was similar to others reported, except for the presence of a palpable and distended gallbladder, later confirmed by right upper quadrant abdominal ultrasound. The findings of an enlarged and distended gallbladder essentially eliminated choledocholithiasis as a cause (Courvoisier's law) and, with evidence of a common duct of normal caliber, pointed to cystic duct obstruction.

The explanation for the otherwise characteristic presentation of cholestasis and biliary colic in this patient with AIDS was found on surgical exploration. Cystic duct compression by enlarged periductal lymph nodes was noted. Cryptococcal lymphadenitis was later conformed by histopathologic examination and culture. The association of cryptococcal visceral lymphadenitis and cystic duct obstruction has not been described previously. Of 61 patients with cryptococcal disease and AIDS, none were found to have biliary tract disease and only one, in fact, had abdominal pain.[8,9] Although concomitant cytomegalovirus or cryptosporidial biliary tract infection could not be excluded, the absence of common duct abnormalities on ultrasound and the normal appearance of bile duct radicals on a liver biopsy suggested that the structural changes seen in other such patients were not prominent in this individual, at least at the time of surgery.

The difficulty in treating disseminated cryptococcsis in patients with AIDS was apparent in this patient. Despite having received over 2 grams of amphotericin B, followed by weekly maintenance doses, progressive cystic duct obstruction due to cryptococcal lymphadenitis occurred. Interestingly, the patient's serum liver function profile worsened following biliary decompression, while she clinically improved. This phenomenon was observed in four of eight patients described by Schneiderman et al and was considered a poor prognostic sign, as two of these individuals later developed biliary sepsis and required further biliary decompression.[6]

Summary

In summary, we have described a patient with AIDS and a previously unreported cause of biliary tract

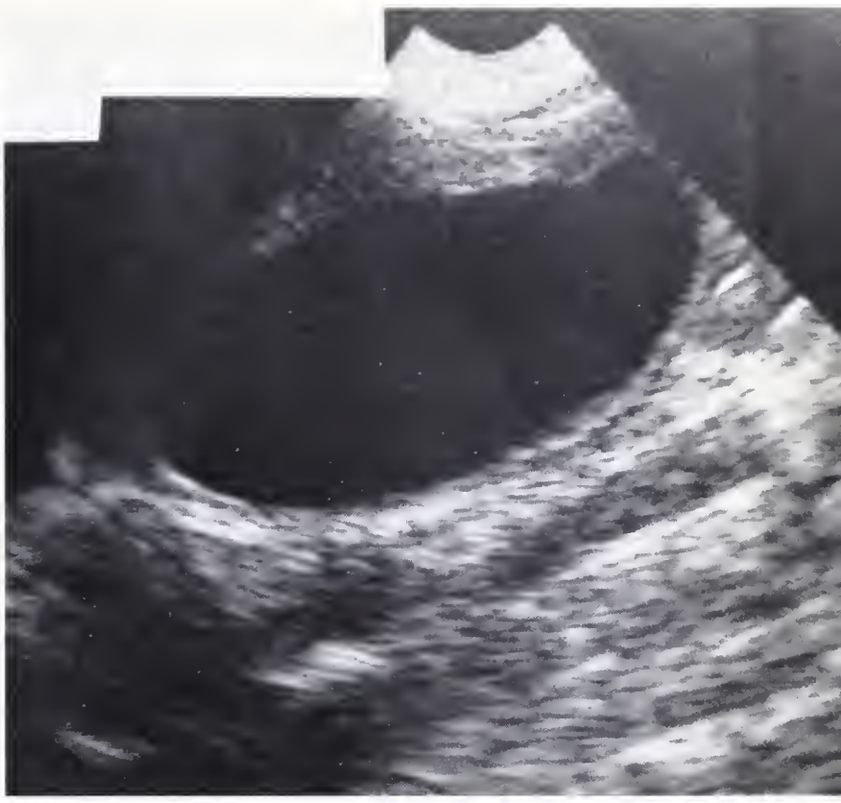
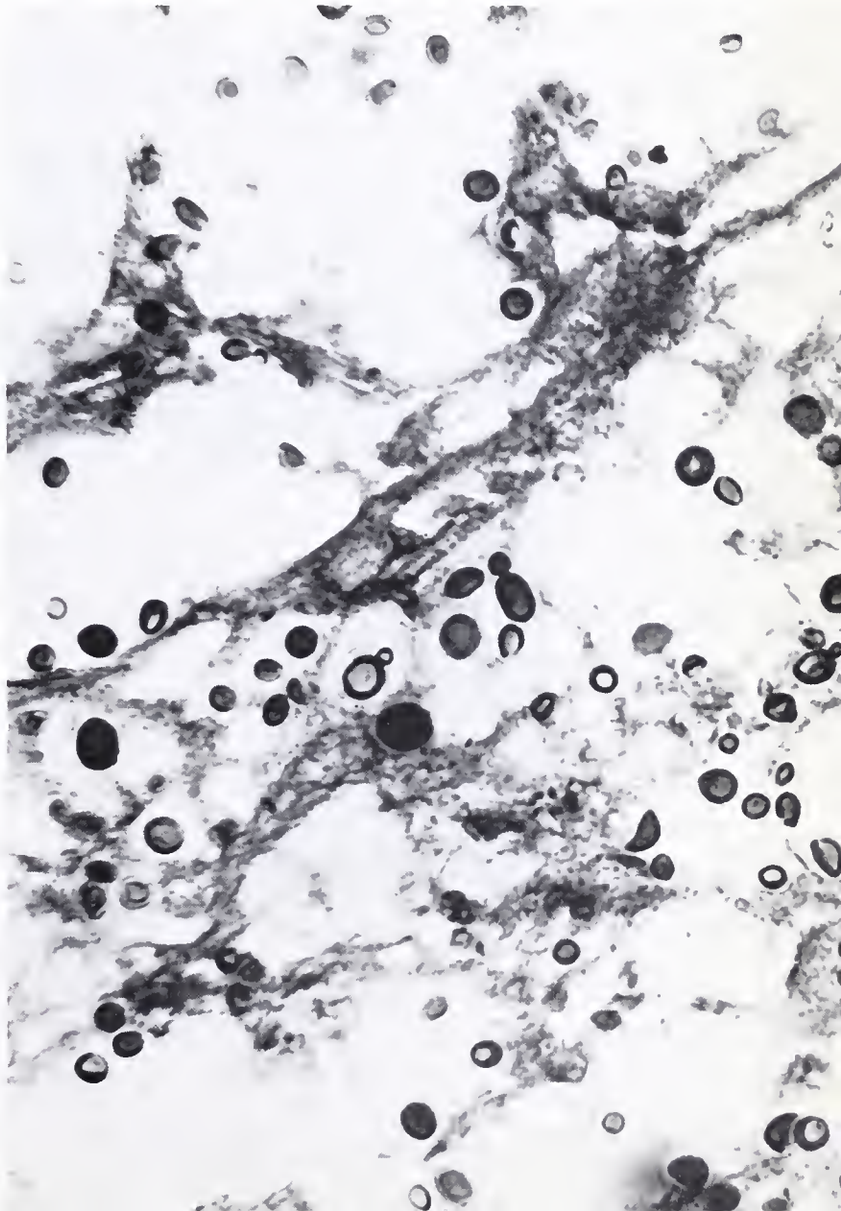


Fig 1A. Two-dimensional ultrasound study showing enlarged, thin-walled gallbladder without stones.

Fig 1B. Lymph node containing multiple encapsulated budding yeast cells, compatible with *Cryptococcus neo-formans* (Gomori methenamine silver stain ×320).



obstruction. The incidence of cryptococcal visceral lymphadenitis in patients with AIDS and disseminated cryptococcosis is unknown, but, if present, is probably clinically silent in most instances. However, in the differential diagnosis of abdominal pain and cholestasis in such patients, one should consider major biliary duct obstruction due to cryptococcal lymphadenitis.

References

1. Pitlik SD, Fainstein V, Rios A et al. Cryptosporidial eholeeystitis [Letter]. N Engl J Med 1983;308:967
2. Dworkin B, Wormser GP, Rosenthal WS et al. Gastrointestinal manifestations of the aequired immunodefieieney syndrome: a review of 22 eases. Am J Gastroenterol 1985;80:774-778
3. Blumberg RS, Kelsey P, Perrone T et al. Cytomegalovirus- and eryptosporidium-assoeiated aealeulous choleeystitis. Am J Med 1984;76:1118-1123
4. Kavin H, Jonas RB, Chowdhury L et al. Aealeulous eholeeystitis and eytomegolavirus infection in the aequired immunodefieieney syndrome. Ann Intern Med 1986;104:53-54
5. Margulis SJ, Honig CL, Soave R et al. Biliary traet obstruetion in the aequired immunodefieieney syndrome. Ann Intern Med 1986;105:207-210
6. Sehneiderman DJ, Cello JP, Laing FC. Palpillary stenosis and selerosing cholangitis in the aequired immunodefieieney syndrome. Ann Intern Med 1986;106:546-549
7. Cello JP. Aequired immunodefieieney syndrome eholangiopathy: spectrum of disease. Am J Med 1989;86:539-546
8. Potter DA, Danforth DN Jr, Maeher AM et al. Evaluation of abdominal pain in the AIDS patient. Ann Surg 1983;199:332-339
9. Kovacs JA, Kovacs UA, Polis M et al. Cryptoeoeeosis in the aequired immunodeficieney syndrome. Ann Intern Med 1986;103:533-538
10. Zuger A, Louis E, Holzman RS et al. Cryptoeoeeal disease in patients with the aequired immunodefieieney syndrome. Ann Intern Med 1986;104:234-240

Tinea Nigra Palmaris in Virginia: Case Report

Samuel T. Selden, MD,
Chesapeake, Virginia

TINEA nigra palmaris is a heavily pigmented, superficial fungal infection, usually involving the palm of a single hand. It is uncommon outside the tropics. I report a case in a Virginia girl, treated with econazole and tretinoin creams.

Case Report

An 8-year-old white girl developed a brown stain on her right palm over the course of 18 months. There had been no scaling, itching or vesiculation. The girl had spent her entire life in Virginia and had never visited beyond the Commonwealth's borders. She denied any chemical exposure or injury.

On examination there was a 25 × 30 mm dark brown stain in the center of her right palm. No elevation or scaling was evident. There was a slight clearing of the lesion's center. Although it appeared as a stain or as dirt, a brisk rubbing with alcohol had no effect on the lesion. The girl's left palm and the plantar surface of her feet were free of lesions.

A scraping was done from the periphery of the lesion, and on potassium hydroxide (KOH) testing, hyphae were visible. A fungal culture prepared on Mycosel's medium eventually produced a grey fuzzy growth, consistent with *Exophiala wernickii*.[1]

Treatment was begun with a twice daily application of 0.01% tretinoin gel and 1% econazole nitrate cream. In two weeks the pigment had faded appreciably. At one month the palm was completely clear and treatment was stopped. Six months later there had been no recurrence.

Discussion

E wernickii infection occurs after penetration of the stratum corneum by the fungus. Over time, a spreading dark stain develops, due to release of fungal pigment. This pigment is superficial and can be scraped or shaved off, differentiating this condition from nevi or melanomas, where the pigment is deeper and impervious to shaving.[2]

Pigmentation of the palm could also be caused by dirt, chemical staining, postinflammatory hyperpigmentation, or melanocytic lesions. In this case, the

Address eorrespondenee to Dr. Selden at Suite 309, 200 Medieal Parkway, Chesapeake VA 23320.

Submitted 8-21-89.

positive KOH test and culture effectively ruled out the other causes.

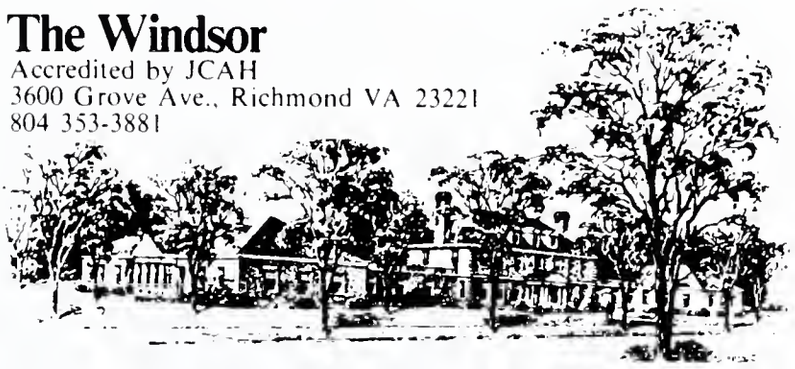
Tretinoin (used as a keratolytic) and econazole successfully cleared the infection. Whitfield's ointment, with salicylic acid as the keratolytic, has been cited as effective in the past. In this case, tretinoin served to strip away the thick palmar stratum corneum to better expose the fungus and to allow more effective penetration of the econazole.

Although not listed as effective against *Exophiala wernickii* in vitro, exonazole, as a new generation antifungal, might be expected to work. Miconazole has been used in the past,[3] but to my knowledge no reference has yet been made in the literature as to the effectiveness of the newer antifungals against tinea nigra.

References

1. McGinnis MR, D'Amato RF, Land GA. Pictorial Handbook of Medically Important Fungi and Aerobic Actinomyces. New York, Praeger, 1982, p 61
2. Findlay GH. Superficial fungous infection. *In* Dermatology in General Medicine, 2nd Edition (Fitzpatrick TB et al, eds). New York, McGraw-Hill, 1979, p 1515
3. Carr JF, Lewis CW. Tinea nigra palmaris: treatment with thiabendazole topically. Arch Dermatol 111:9041, 1975

The Windsor
Accredited by JCAH
3600 Grove Ave., Richmond VA 23221
804 353-3881



LONG-TERM CARE: IN SIXTH DECADE OF EXCELLENCE

Mrs. Plyler's
Residential Care
1615 Grove Ave., Richmond VA 23220
804 353-3981

University Park
Accredited by JCAH
2420 Pemberton Rd., Richmond VA 23233
804 747-9200

VIRGINIA MEDICAL

Changing Perspectives: Coronary Artery Disease

Coronary artery bypass surgery continues to impact significantly on the management of patients with coronary artery disease. While symptomatic benefits of surgery have long been recognized, defining longevity benefits has been slower. Decisions regarding appropriate patient selection for specific therapeutic management is clearer today. For example, factors predicting the most demonstrable survival benefits of bypass surgery include the extent of coronary artery disease, the extent of left ventricular dysfunction and the severity of demonstrable ischemia. Physicians are more appropriately attuned to these factors and as a consequence the patient population referred for surgery is changing, i.e., patients with poor left ventricular function, worse coronary disease, and even the elderly are now commonplace. As a consequence, mortality has increased but comparative studies of medical versus surgical therapy have demonstrated that certain high-risk patient groups, particularly those having left ventricular impairment with more extensive coronary disease[1] or severe ischemia, such as unstable angina,[2] experience improved cumulative yearly survival following bypass surgery.

In addition, the elderly can also benefit from surgical revascularization, though at a slightly increased risk.[3] The importance for the elderly may actually be greater, as myocardial hypertrophy, which appears with age, seems to decrease these patients' tolerance to ischemic events, thereby increasing the potential impact of revascularization.

Thus, as a consequence of these findings, a changing coronary surgical population is occurring, as pointed out by McManus and colleagues in this issue of Virginia Medical. However, the late outcome for appropriately selected high-risk patients is nonetheless enhanced. This message must be transmitted to review organizations and to the public: Treatment outcomes are clearly dependent upon patient selection, but selecting appropriate high-risk patients may ultimately improve outcome.

Finally, coronary angioplasty has reduced the number of patients with one- and sometimes two-vessel disease undergoing bypass surgery for medically uncontrolled symptoms with quite acceptable morbidity and mortality results.[4] Multiple randomized trials comparing surgery versus angioplasty for more extensive disease are ongoing and should help to again better define those populations most likely to benefit from bypass surgery.

Decision-making and technology continue to evolve. The challenge remains to appropriately select patients who may potentially achieve the greatest survival and symptomatic benefits from our therapeutic decisions.

George W. Vetrovec, MD

Department of Internal Medicine, Division of Cardiology
Medical College of Virginia/VCU
Box 36, MCV Station, Richmond VA 23298

1. Passamani E, Davis KB, Gillespie MJ, Kilip T, and the CASS Principal Investigators and Their Associates. A randomized trial of coronary artery bypass surgery: Sur-

vival of patients with a low ejection fraction. N Engl J Med 1985;312:1665-71
2. Parisi AF, Khuri S, Deupree RH et al. Medical compared with surgical management of unstable angina: 5-year mortality and morbidity in the Veterans Administration Study. Circulation 1989;80:1176-1189
3. Edmunds LHJr, Stephenson LW, Edie RN, Ratcliff MB. Open-heart surgery in octogenarians. N Engl J Med 1988;319:131-6
4. Detre K, Holubkov R, Kelsey S et al. Percutaneous transluminal coronary angioplasty in 1985-86 and 1977-81. The National Heart, Lung, and Blood Institute Registry. N Engl J Med 1988;318:265-270

Medical School Applications

According to the Association of American Medical Colleges (AMA News, 17 November 1989), the 14-year decline in applications to medical schools may have bottomed out. On the basis of applications received by the first week of November 1989, the AAMC estimates that the number of applicants for admission to medical schools next year will top the 1989 applications by about 1,000. Virginia medical schools report a similar response.

Applications to the Medical College of Virginia/VCU are up by 25%; Eastern Virginia Medical School has experienced a 30% increase; and 11.2% more applications have been received by the University of Virginia School of Medicine.

The reasons for this increased interest in medicine? The AAMC suggests that the increase in applications may be due to the current ratio of 1.6 applicants for each medical school slot, an historic low. However, Dr. Robert Beran, assistant vice president, AAMC, notes that all other health professional schools also have experienced an increase in applications.

Admissions officers of the three Virginia medical schools likewise are unable to provide a specific answer to the increased number of applications. In Norfolk, Dr. Robert McCombs suggests that EVMS recruiting and increased interest in out-of-state students may be a major factor. Further, the school has become more widely known.

Dr. Edwin Pullen, University of Virginia dean of admissions, notes two factors: more active recruiting by medical schools and the perception of instability in business, as evidenced by the 1987 stock market crash.

At MCV, Dr. Kenneth Blaylock agrees that the greater likelihood of admission (1.6 ratio of applicants to medical school slots) has activated more candidates. He further agrees with Dr. Pullen that medicine is more widely perceived as a desirable profession.

Other factors in the trend, as noted by the AAMC and seconded by Dr. Blaylock, appear to be a rise in applications from women and minorities, particularly Asian Americans. On the other hand, there has been a decrease in applications by white males.

E.L.K., Jr.

Great Communication

I knew her well, both socially and professionally, and I liked her. After she began to develop cataracts, I made more than my usual effort to explain the advancing problem to her.

Her lens opacities slowly grew worse. Finally new glasses would not improve her visual disability, and cataract surgery was obviously necessary.

I explained why new glasses would, again, not help and why only cataract removal offered her a chance for improved eyesight. With a model eye I went into detail about what cataract surgery entailed.

She wanted to think it over and returned in a week with a few questions which I answered with great skill and clarity. Just to be absolutely certain that she understood completely, I again gave a superlative explanation with the model eye. She obviously understood by her facial expression and by her having no more questions. So we scheduled her surgery.

She returned to see my partner the next day to have ultrasound measurement of her eye in order to calculate the power of the planned intraocular lens implant. After that determination was completed, she and my partner chatted.

Just as she was preparing to leave, she turned to my partner and said, "Don, please answer some questions for me. Henry never tells me anything."

H.S. Campell, MD

VIRGINIA MEDICAL OBITUARY

• **Sterling Neblett Ransome, MD,** Mathews, a past president of the Mid-Tidewater Medical Society; Medical College of Virginia, 1956; age 63; died January 5, 1990. Dr. Ransome retired from practice in 1989.

• **Douglas Doriot Vance, MD,** longtime family physician in Bristol, Tennessee; University of Virginia School of Medicine, 1928; age 93; died April 14, 1989.

• **Lewis Emmor Wells, MD,** retired Farmville internist; University of Pittsburgh School of Medicine, 1931; age 83; died October 31, 1989, in Fayetteville, North Carolina.

Memoir of George Hurt 1889-1989

By Alexander McCausland, MD, and William Kaufman, MD

It is with a great sense of loss that we present this memorial resolution for our oldest, longest standing member and past president (1935-36) of the Roanoke Valley Academy of Medicine.

Dr. George Samuel Hurt was born in Elizabethtown, Kentucky, December 4, 1889. He died in Roanoke, Virginia, March 28, 1989, at the age of 99.

Dr. Hurt was educated at Fork Union Military Academy and the Medical College of Virginia. He began the practice of medicine in Roanoke in 1913 and continued until he was commissioned in the army July 6, 1917. He helped organize Ambulance Company No. 46, which eventually became Ambulance Company No. 319, a unit of the 80th Infantry Division. On May 1, 1918 the division embarked for France, where upon arrival Dr. Hurt's company was assigned to the British Army, serving at the front until reassigned to the American Army.

On September 15, 1918, his unit was in reserve during the St. Mihiel Offensive. It then moved to an area in the American sector northwest of Verdun. An advance dressing station was set up in preparation for the Meuse-Argonne offensive, which began the morning after arrival. Dr. Hurt continued to follow the advance through all three phases of the offensive. During the winter of 1918-19 while billeted at Pimmells, France, he started a hospital for his own men which later became the division hospital and which operated as such until the movement began for the journey home. He refused many opportunities to leave the lines for a rest period and, although severely gassed, remained at his post until his division was relieved two days before the Armistice. For these acts of distinction he was awarded the service cross. The citation read: "At Natillois while maintaining a dressing station under severe shell fire, Lieutenant Hurt was severely gassed, the eyes and face were burned and laryngitis and bronchitis developed, causing a loss of voice for about two weeks and a cough that lasted two months. Regardless of these painful and incapacitating conditions, Lieutenant Hurt refused to be evacuated and not only maintained his own station but was instrumental in establishing and supervising other stations. This officer was one of the most progressive, efficient and tireless workers in Ambulance Company 319 and during the thickest fighting was known to have worked 72 hours without sleep."

Dr. Hurt was discharged May 19, 1919, and returned to Roanoke to resume his medical practice. He was a member of the Disabled Soldiers of America and the American Legion, and was commander of the Roanoke American Legion Post. He was very active in obtaining aid for widows and orphans of former soldiers.

He served many posts in the Calvary Baptist Church: He was a Sunday School teacher, he served on the Board of Finance, he was chairman of the Board of Deacons, superintendent of Sunday School, chairman of the brotherhood, chairman of the Nominating Committee, chairman of the Pastor Procurement Committee and chairman of the Library Committee. He served as a trustee of the church. He contributed also to special missionary undertakings abroad. In 1960 the church honored him by making him deacon emeritus.

Dr. Hurt was a member and president of the Roanoke Academy of Medicine (1935-36), member of the Virginia Association of Gynecologists and Obstetricians, the Roanoke Association of Gynecologists and Obstetricians, and first vice president of The Medical Society of Virginia. He served as president of the YMCA and as a member of the United Fund. During World War II, he was appointed senior surgeon in the United States Public Health Service, serving in that capacity as a consultant. During World War II he served as a member of the Selective Service System for four years, for which he was awarded the Certificate of Merit signed by President Roosevelt. He also received the Certificate of Merit for Distinguished Service to the USO, signed by Truman.

Dr. Hurt married Miss Corinne Lockett May 8,

1918. They had one daughter, Mrs. Corinne Hurt Turner, and three sons. George William Hurt, David Edgar Hurt, and Alvin Judson Hurt. Two of the sons, Drs. George and Alvin Hurt, followed in their father's footsteps in the practice of obstetrics and gynecology in Roanoke. A grandson, George Samuel Hurt III, practices urology in Martinsville, Virginia. There are six grandchildren and seven great-grandchildren.

Dr. Hurt was always immaculately dressed. He never failed to wear a flower, especially a rose, in his lapel. A testing in the fires of World War I was succeeded by a serene maturity and old age, which the flower in the buttonhole symbolized. "And the fire and the rose are one," wrote T. S. Eliot.

The interns, residents and nurses considered Dr. Hurt their favorite physician. The Jefferson Hospital Nurses Alumni Association memorialized Dr. Hurt with a contribution to the Memorial Chapel Fund at Community Hospital of Roanoke Valley.

If friends or members of a doctor's family were in the hospital, Dr. Hurt was the first to pay them an encouraging personal visit. He never missed his daily visits while they were in the hospital. His hospital rounds included not only his patients, but also a good-morning visit to the lab, x-ray, record room, administrative offices and dietary department. If a doctor was needed at the blood bank, he was always willing to serve.

Sunday afternoon found Dr. Hurt making home and personal visits to friends and acquaintances. He was a friend to the young and new doctors, and a wise counselor to all doctors. To the interns and residents he was an inspiration.

With Dr. Hurt's passing our city and our state lost a great and good servant. Medicine has lost a dedicated physician who practiced in keeping with the highest traditions of American medicine. He gave much to medicine and through it, to his fellow men. We who were privileged to know him have lost a warm and loyal friend.

News of the death of a Medical Society of Virginia member may appear in these pages in either or both of two ways: 1) a brief notice written by staff giving factual information; 2) a memoir contributed by a physician who knew the deceased peer and writes a personal account of his or her life. If the memoir is contributed before the brief notice is inserted, it is published at once; if after, it is set in type to be published as space permits.

MEDICAL SOCIETY OF VIRGINIA

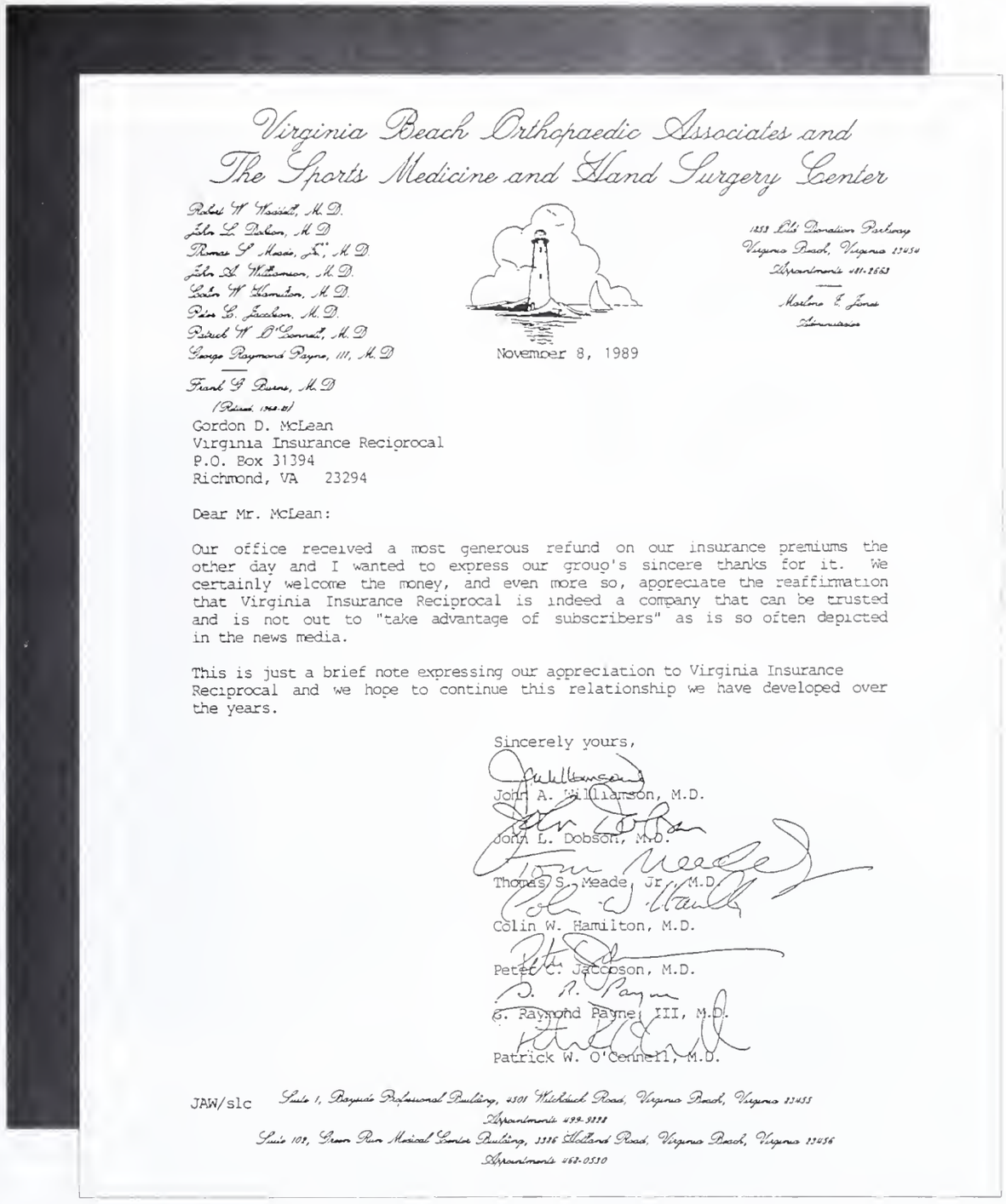
President
William H. Barney, MD, Lynchburg
President Elect
John A. Owen, Jr., MD, Charlottesville
Immediate Past President
J. Thomas Hulvey, MD, Abingdon
First Vice President
Leon I. Block, MD, Falls Church
Second Vice President
William W. Regan, MD, Richmond
Third Vice President
William H. Sipe, MD, Newport News
Speaker
George E. Broman, MD, Culpeper
Vice Speaker
Lawrence K. Monahan, MD, Roanoke

Councilors by District
1st: **Louis D. Parham, MD,** Hampton
2nd: **Russell D. Evett, MD,** Norfolk
3rd: **James A. Shield, Jr., MD,** Richmond
4th: **John W. Hollowell, MD,** Portsmouth
5th: **Edwin J. Harvie, Jr., MD,** Danville
6th: **Jeffrey W. Wilson, MD,** Lynchburg
7th: **H. George White, Jr., MD,** Winchester
8th: **Ira J. Green, MD,** Alexandria
9th: **James L. Patterson, Jr., MD,** Pulaski
10th: **Ira D. Godwin, MD,** Fairfax

AMA Delegates
H. C. Alexander III, MD, Roanoke
Raymond S. Brown, MD, Gloucester
Charles M. Caravati, Jr., MD, Richmond
C. Barrie Cook, MD, Falls Chruch
Richard L. Fields, MD, Fairfax
William J. Hagood, Jr., MD, Clover
John A. Martin, MD, Roanoke
Harold L. Williams, MD, Newport News
Percy Wootton, MD, Richmond

Executive Vice President
James L. Moore. Jr.

Don't take our word for it...



Virginia Beach Orthopaedic Associates and
The Sports Medicine and Hand Surgery Center

Robert W. Wassell, M.D.
John L. Dobson, M.D.
Thomas S. Meade, Jr., M.D.
John A. Williamson, M.D.
Colin W. Hamilton, M.D.
Peter C. Jacobson, M.D.
Patrick W. O'Connell, M.D.
George Raymond Payne, III, M.D.

Frank G. Evans, M.D.
(Retired, 1988-89)

1253 Lila Donaldson Parkway
Virginia Beach, Virginia 23454
Appointments 481-2553

Marlene E. Jones
Administrator

November 8, 1989

Gordon D. McLean
Virginia Insurance Reciprocal
P.O. Box 31394
Richmond, VA 23294

Dear Mr. McLean:

Our office received a most generous refund on our insurance premiums the other day and I wanted to express our group's sincere thanks for it. We certainly welcome the money, and even more so, appreciate the reaffirmation that Virginia Insurance Reciprocal is indeed a company that can be trusted and is not out to "take advantage of subscribers" as is so often depicted in the news media.

This is just a brief note expressing our appreciation to Virginia Insurance Reciprocal and we hope to continue this relationship we have developed over the years.

Sincerely yours,

John A. Williamson, M.D.
John L. Dobson, M.D.
Thomas S. Meade, Jr., M.D.
Colin W. Hamilton, M.D.
Peter C. Jacobson, M.D.
G. Raymond Payne, III, M.D.
Patrick W. O'Connell, M.D.

JAW/slc

Suite 1, Bayside Professional Building, 4501 Pinchbeck Road, Virginia Beach, Virginia 23455
Appointments 499-9998
Suite 109, Green Run Medical Center Building, 3316 Holland Road, Virginia Beach, Virginia 23456
Appointments 467-0530

[Unsolicited testimonial from one of the many thousands of physicians' groups which received an equity return distribution during 1989.]

Call us . . . we reciprocate.

The Virginia Insurance Reciprocal

4200 Innslake Drive
Glen Allen, Virginia 23060
Toll free: 1 800 284-TVIR—In Richmond: 747-8600

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85

AVAILABLE AT PHARMACIES NATIONWIDE

PALISADES PHARMACEUTICALS, INC.
219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

Advice to Authors

Copyright of an article published in VIRGINIA MEDICAL is retained by the author, but the copyright to each entire issue as a collective work is the property of The Medical Society of Virginia, and permission to reprint all or any part of a published article must be negotiated with the author and the Editors jointly. The reprinted material must carry a credit line signifying that it first appeared in VIRGINIA MEDICAL.

Manuscript Preparation

Medical articles, editorials, essays, Letters to the Editor and all other text submitted for publication must be double-spaced throughout, including references, legends and all other elements. The material should be typed on one side of the paper, with generous margins of at least 1¼ inches all around. Do not use all-caps or a script typeface. Submit one original of the communication and one copy. If the material is not accepted, the original will be returned; the copy will be retained.

The author is responsible for the accuracy of all statements and references. Acronyms and other abbreviations should be kept to a minimum; unless an acronym is widely known and used by all specialties, it should be fully explained in the text. Refer to pharmaceutical products by their generic names; brand names may follow in parentheses and should carry registered trademarks where applicable. All units of measure should appear in the metric system. References, typed in double-space, should be listed in the order of their citation in the text, not alphabetically. They should follow VIRGINIA MEDICAL's typographic style for references; the typist should study this style as it appears in each issue.

Illustrations should be black and white glossy prints, with legends typed in double-space on a separate sheet of paper. VIRGINIA MEDICAL has no budget for printing in color; the author who wishes to publish a four-color figure may negotiate to pay for the costs.

Attach to the contribution a covering letter giving the address and telephone number of the person who will correspond about it and address the completed communication to the Editors, VIRGINIA MEDICAL, 4205 Dover Road, Richmond VA 23221.

All manuscripts are subject to editorial changes. If extensive revision is deemed necessary, the author will receive for approval a draft of the article as edited.

There are many excellent handbooks of effective writing, among them *The Elements of Style,* by William Strunk, Jr., and E. B. White (MacMillan); *The Careful Writer: A Modern Guide to English Usage,* by Theodore M. Bernstein (Atheneum); and *How to Write and Publish a Scientific Paper,* by Robert A. Day (ISI Press).

YOU WORRY ABOUT PATIENTS

LET US WORRY ABOUT YOUR PRACTICE

YOUR COLLECTIONS

YOUR GROWTH

YOUR CASH FLOW

YOUR STATISTICS

YOUR BILLING

YOUR FINANCES

YOUR PAYROLL

YOUR FUTURES

t Integrated Office Solutions, Inc. (IOS), we provide financial security for practices through our sophisticated medical anagement software. This software combines the latest methods of user friendly software techniques to offer a fully integrated anagement system designed exclusively for physicians. The benefits ensure increased productivity, organization, and accuracy. lore importantly, month end close and insurance billing is decreased to several hours, instead of several days.

enefits of automation: Improve cash flow monitoring
Raise collection percentage
Organize financial information for CPA's
Provide practice analysis for growth and future

)S has taken a position to build on our reputation of outstanding service and unprecedented support of our clients. Our ntinued success depends on providing your practice with the best medical software now and in the future. Our selection as n Agent and Business partner with IBM is also an indication of the confidence IBM has in our software and our company's bility to install and support the AS/Entry and AS/400 family of computers.

o ahead, let IOS and IBM worry about your practice. Call today for a no charge survey and analysis of your computer needs. emember, when you automate your practice, you will have more time to worry about others. (Your patients will love you.)

Integrated Office Solutions, Inc.

1603 Santa Rosa Rd.,
Suite 108
Richmond, Virginia 23229
(804) 282-3785

IBM Business Partner
Authorized Agent

The Medical Society of Virginia Approved I.C. System's Collection Program on July 17, 1984

Today more than 500 member practices are enrolled and have recovered more than $4 million in overdue receivables.

I.C. System is endorsed as a responsible alternative for members who need help keeping their receivables under control. All collection practices are legal, ethical and professional. The objective is to collect without harming the doctor patient relationship. That's important.

In these difficult times you need a collection program you can turn to in confidence. Consider I.C. System. Return this form, or call us at 1-800-443-4123, Ext. 621. The system is endorsed by the Society. The System Works!

Tell me more about this program endorsed by the Medical Society of Virginia.

Practice_____

Address_____

City_____ State_____ Zip_____

Phone_____

Send to: I.C. System, Inc.
444 East Highway 96
P.O. Box 64444
St. Paul, Minnesota 55164

COMMITTED TO EXCELLENCE

ROCHE

PRESIDENT'S ACHIEVEMENT AWARD

Presenting the winners of the 1989 Roche President's Achievement Awards

Roche Laboratories is proud to honor these outstanding sales representatives, chosen for their unparalleled dedication to the healthcare field, professionalism and consistent high level of performance. Please join us in congratulating these exceptional individuals.

Kathy Mortez-Hagy

Mohamed E. Nouh

Eric W. Spangler

Turn to the following page and find out how your award-winning Roche representative can help both you *and* your patients.

Your Roche Representative Would Like You To Have Something That Will...

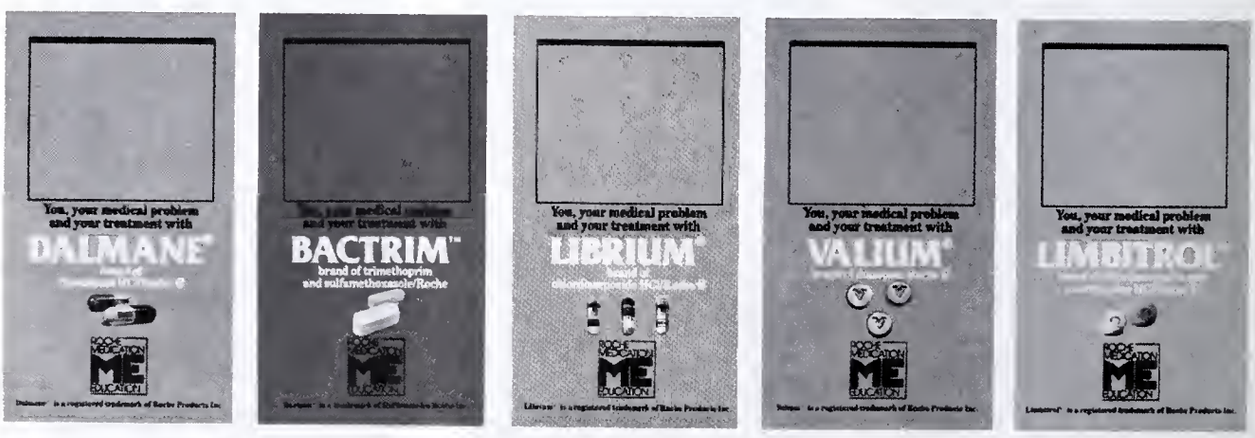
ROCHE®

... improve patient satisfaction with office visits.
... improve patient compliance with your instructions.
... reduce follow-up calls to clarify instructions.

Roche product booklets ...

- offer a supplement to, not a substitute for, patient contact.
- support your specific instructions to the patient.
- provide a long-term reinforcement of your oral counseling.
- are available in *Spanish*.

Because you are the primary source of medical information for your patients, we invite you to look over the Roche product booklets shown below. Ask your Roche representative for the new catalog brochure of patient education materials and for a complimentary supply of those booklets applicable to your practice, including the WHAT IF Book in large type.



ROCHE ME MEDICATION EDUCATION

Working today for a healthier tomorrow

SEVEN WAYS TO SHARPEN YOUR MEDICAL SKILLS.

The Army Reserve offers a number of highly specialized medical courses you can't always get in civilian hospitals—with the kind of flexibility your busy schedule demands. Here is just a sampling of the unique training programs available to you in the Army Reserve:

COMBAT CASUALTY CARE Prepares you for treating trauma patients in your civilian career. Learn how to live, survive, and function in challenging environments.

ADVANCED TRAUMA/LIFE SUPPORT Teaches you how to treat trauma patients during the critical first hour of injury. Sponsored by the American College of Surgeons.

ADVANCED BURN LIFE SUPPORT Teaches you how to treat and manage the unique characteristics of the burn patient. Sponsored by the American Burn Association.

ADVANCED CARDIAC LIFE SUPPORT Centers upon the treatment and life-saving intervention associated with the acute cardiac patient. Sponsored by the American Heart Association.

TROPICAL MEDICINE Provides you with advanced in-depth training in parasitology, infectious diseases occurring in tropical and other areas of the world, and other related topics.

FLIGHT SURGEON Gives you a working knowledge of aviation medicine in a course that offers opportunities for frequent operational flights.

AVIATION MEDICINE Offers you a follow-up to the Flight Surgeon course and includes air ambulance operations, airfield operations, and aeromedical research.

Join a local medical unit and serve as few as 16 hours a month and 14 days of active duty during the year. The time you serve can be scheduled around your busy private practice.

You might also have the opportunity to participate in our Individual Mobilization Augmentee Program and serve just two weeks each year.

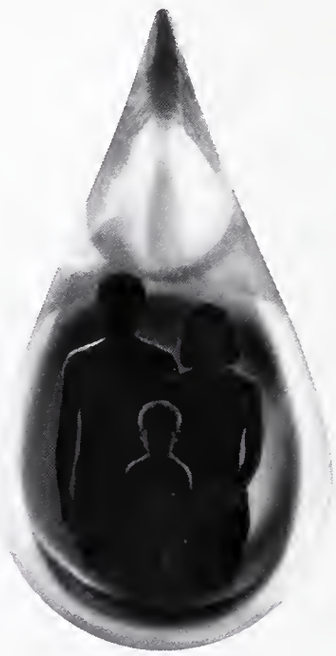
If you would like more information about these or other medical opportunities, or would like to be contacted by an Army Reserve physician, call 1-800-USA-ARMY.

ARMY RESERVE MEDICINE. BE ALL YOU CAN BE.®

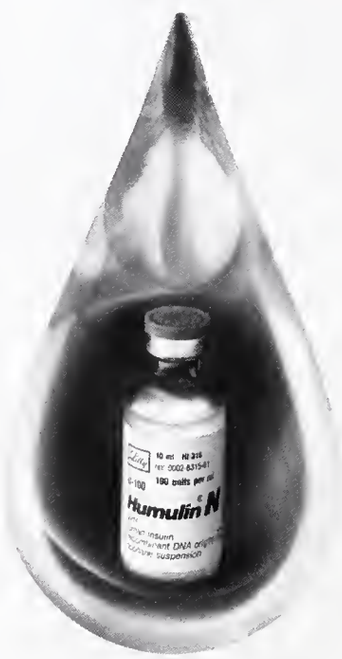
For treatment of diabetes:

Introducing
Humulin® 70/30
70% human insulin isophane suspension
30% human insulin injection
(recombinant DNA origin)

REPLACE
Human Insulin



With Human Insulin



Humulin®
human insulin
(recombinant DNA origin)

Any change of insulin should be made cautiously and only under medical supervision.

Lilly Leadership In Diabetes Care

© 1989, ELI LILLY AND COMPANY HI-2914-B 949334

MEETINGS

April 1-4
Conference on AIDS (Johns Hopkins), *Baltimore*. Registration, 1-800-334-8644.

April 4
37th Annual Clinical Conference (Obici Hospital), *Suffolk*. George J. Carroll, MD, 804-934-4000.

April 6-8
Mammography: Current Concepts and Interpretation (Eastern Virginia Medical School), *Williamsburg*. CME Office, 804-446-6140.

April 6-8
Annual Ophthalmology Conference: Cornea and External Disease (Medical College of Virginia/VCU), *Williamsburg*. CME Office, 804-786-0494.

April 12
Newer Infectious Diseases: Plagues of the 1990s (Southwest Virginia Medical Society), Ramada Inn, *Wytheville*. 4½ credit hrs. Kenneth J. Walker, MD, 703-921-3636.

April 19-21
Annual Meeting, Virginia Society of Otolaryngology/Head and Neck Surgery, *Alexandria*. Donna Scott, 804-353-2721.

April 19-22
10th Edition, Clinical Electrocardiography: Basic Concepts and Interpretation (Eastern Virginia Medical School), *New Orleans, Louisiana*. CME Office, 804-446-6140.

April 20-22
12th Annual Emergency Medicine for the Primary Care Physician (Medical College of Virginia/VCU), *Williamsburg*. CME Office, 804-786-0494.

April 21
Regular meeting of the Medical Society of Virginia's Council, *Richmond*. James L. Moore, Jr., 804-353-2721.

April 24
Common Problems in Primary Care (Fairfax Hospital), *Falls Church*. Cathy Sarraf, 703-698-2572.

April 26-29
11th Edition, Practical Dermatology for the Primary Care Physician (Eastern Virginia Medical School), *New Orleans, Louisiana*. CME Office, 804-446-6140.

April 27
2nd Annual Virginia Heart Center Symposium (Fairfax Hospital), *Falls Church*. Cathy Sarraf, 703-698-2572.

April 27-29
25th Annual Pediatric Springfest (Medical College of Virginia/VCU), *Williamsburg*. CME Office, 804-446-6140.

continued on page 132

You're Invited

The purpose of VaMPAC is to support political candidates who are sympathetic to physicians' concerns on medical and health issues by offering services, monetary support, and warm bodies.

VaMPAC is the non-partisan political action arm of the Medical Society of Virginia and is for neither Republicans nor Democrats but for our political friends.

A goal of VaMPAC is to convince those who are neutral, or even hostile, to our concerns to become our friends. And if we cannot make a friend, we try not to make an enemy, because some day we may be able to make him/her a friend.

Another goal of VaMPAC is to educate physicians about political issues, which sometimes is the more difficult task.

VaMPAC is run by a Board of Directors of thirty-five MSV members who desperately want and need your input. They invite you to come to their meetings to see how your political action committee functions. Here is the 1990 meeting schedule:

April 17, 2:30 pm, Richmond, place to be announced

June 16, 10:30 am, Richmond, MSV headquarters

September 22, 10:30 am, Richmond, MSV headquarters

November 1, the Homestead, time to be announced

If you have questions, call Jo Parkin in the VaMPAC office at MSV headquarters, 804-353-2721.

VaMPAC

MORE MEETINGS

May 3-6
Annual Meeting of the Virginia Chapter, American College of Radiology, the Homestead, *Hot Springs*. Patricia R. Berry, 703-669-8312.

May 4-6
10th Annual Clinical Concerns in Primary Care (Medical College of Virginia/VCU), *Williamsburg*. CME Office, 804-446-6140.

May 5
Nutritional Support of the Trauma Patient (Fairfax Hospital), *Falls Church*. Cathy Sarraf, 703-698-2572.

May 8
8th Annual Ethics Symposium: The Dilemma of Fetal Viability—Medical and Legal Impact on the Delivery of Health Care (Fairfax Hospital), *Falls Church*. Cathy Sarraf, 703-698-2572.

May 10-13
Annual Meeting, Virginia Orthopaedic Society, *Wintergreen*. Donna Scott, 804-353-2721.

May 14-18
Topics in Clinical Medicine (Johns Hopkins), *Baltimore*. 40 credit hrs. Fee, $650. CME Office, 955-2959.

May 25-27
Advances in Pediatrics (American Academy of Pediatrics), *Hilton Head Island, South Carolina*. 16 credit hrs. CME Registration, 800-421-0589.

May 26-28
11th Annual Urogynecology and Pelvic Surgery (Medical College of Virginia/VCU), *Williamsburg*. CME Office, 804-786-0494.

June 4-8
6th Edition, Family Medicine Review Course (Eastern Virginia Medical School), *Virginia Beach*. CME Office, 804-446-6140.

June 4-8
General Surgery Seminar: Update and Review (Lloyd Noland Hospital), *Hilton Head Island, South Carolina*. CME Office, 205-783-5276.

June 6-10
7th Annual Meeting of the Southern Orthopaedic Association, *Maui, Hawaii*. Kathy McLendon, 205-945-1848.

June 7-9
Update in Obstetrics (American College of Obstetricians/Gynecologists), *Norfolk*. 16 credit hrs. Fee, $515. ACOG Registrar, 800-673-8444.

June 7-10
14th Annual Postgraduate Course on Rehabilitation of the Brain-Injured Adult and Child (Medical College of Virginia/VCU), *Williamsburg*. CME Office, 804-786-7290.

June 11-15
Adult Infectious Disease Seminar: Current Update (Lloyd Noland Hospital), *Hilton Head Island, South Carolina*. CME Office, 205-783-5276.

June 14-16
35th Annual Great Smokey Mountains Pediatric Seminar (University of Tennessee), *Gatlinburg, Tennessee*. Abby Hall, 615-544-9190.

June 15-16
Arrhythmnias: Interpretation, Diagnosis and Management (Medical Education Resources), *Williamsburg*. Deborah Helton, 800-421-3756.

June 19-23
Pediatric Infectious Disease Seminar: Current Update (Lloyd Noland Hospital), *Hilton Head Island, South Carolina*. CME Office 205-783-5276.

June 21-24
Annual Meeting, Virginia Society of Ophthalmology, *Norfolk*. Donna Scott, 804-353-2721.

June 22-24
Clinical Pediatrics (American College of Pediatrics), *Washington, DC*. 16 credit hrs. CME Registration, 800-421-0589.

SERIAL LEARNING PROGRAMS

Colby College in Waterville, Maine, has presented continuing medical education courses since 1945, building a national reputation for courses of quality in a pleasurable summer milieu. Physicians and their families are accommodated on campus. The courses offered in 1990 are listed below; all are accredited for Category I. For further information, write or call Robert H. Kany, Director of Special Programs, Colby College, Waterville ME 04901, 207-872-3000.

June 17–29, Orthopedics; 60 credit hrs; tuition, $1000
June 24–29, Family Practice, 26 hours, $400
July 8–11, Addiction Medicine, 14 hrs, $360
July 9–10, Child Abuse, 12 hrs, $150
July 9–13, Allergy/Asthma/Dermatology, 18 hrs, $400
July 9–13, Pediatrics, 16 hrs, $400
July 15–17, Gastroenterology, 12 hrs, $300
July 17–20, Urology, 15 hrs, $375
July 17–20, Surgical Techniques, 15 hrs, $400
July 22–26, Ophthalmology, 18 hrs, $450
July 23–27, Anesthesiology, 15 hrs, $375
July 29–August 3, Obstetrics/Gynecology, 22 hrs, $500
July 30–August 2, Diabetes, 15 hrs, $375
July 30–August 3, Otolaryngology, 18 hrs, $450
August 12–16, Emergency Medicine, 24 hrs, $400
August 12–16, Forensic Medicine, 34 hrs, $400

C U M B E R L A N D

A Hospital for Children and Adolescents

Call For Papers

3rd Annual Cumberland Hospital Conference

Treating Head Injury and Chronic Illness In Children and Adolescents Focus on: The Problem Patient, Transdisciplinary Approaches

September 13–15, 1990
Williamsburg, Virginia

General Information

- Those selected to present papers at the conference will be assigned a 30-minute slot during the conference for a platform presentation. All types of research, case studies or other information may be submitted for consideration. The goal of the conference is to present a broad scope of valuable information to attendees.
- Accepted authors are eligible for a reduced tuition of $100 (full tuition is $175). If more than one person is presenting the paper, all will receive the reduced tuition.
- All submissions must be postmarked before May 1, 1990. If selected, the author's name, title and topic will appear in the conference brochure. Authors will be notified by May 15, 1990.

Submission Requirements

- In a maximum of two typed pages, tell the conference committee about your proposed presentation and why attendees will be interested in the topic.
- Include with the two typed pages, your Curriculum Vitae.
- Also include with the proposal any other information which may assist the committee make a decision.
- All materials should be mailed to:
  Conference Committee
  Cumberland Hospital
  P.O. Box 150
  New Kent, VA 23124

Conference Location

The Conference will be held at the Williamsburg Hilton Hotel. The conference facility is located only a few miles from Colonial Williamsburg and at the entrance to "Busch Gardens, the Old Country."

Additional Information

For additional information on the conference, contact the Information Office of Cumberland Hospital for Children and Adolescents at 1-800-368-3472.

VIRGINIA MEDICAL CLASSIFIED

Virginia Medical classified ads accepted at the discretion of the Editor. Rates to Medical Society of Virginia members: $15 per insertion up to 50 words, 25¢ each additional word. To non-members: $30 per insertion up to 50 words, 25¢ each additional word. Deadline: 5th day of month prior to month of publication. Send to the Advertising Manager, 4205 Dover Road, Richmond VA 23221.

PEDIATRICIAN—Full-time/part-time to join Family Practitioner who is returning to rural practice. Office available. Area is rapidly becoming suburban; many young families moving in. Contact Dr. Frank Sasser, Box 825, Route 3, Montpelier VA 23192, phone 804-883-5374, 804-883-5260, 804-798-2825.

NORTHERN VIRGINIA—Fifteen minutes from Washington, D.C. Immediate opening for FP with specified interest in pediatrics. C.V. to Carl Hanfling, MD, 7501 Little River Turnpike, Annandale VA 22003, (703) 256-5680.

RICHMOND, VIRGINIA—Seeking part-time residents in primary care specialties to provide double coverage in active ED. Competitive compensation and hours. Malpractice insurance provided. Contact: Emergency Consultants, Inc., 2240 S. Airport Rd., Room 40, Traverse City MI 49684, 1-800-253-1795 or in Michigan 1-800-632-3496.

MARYLAND EASTERN Shore—Dynamic 6-man Emergency Medicine group seeks ABEM BE/BC associate. Level II, 24-bed regional trauma center w/47K annual visits serves drawing area of 250K at progressive 373-bed tertiary care facility. Location on the Delmarva peninsula is water sports lovers' paradise with ocean, Chesapeake Bay, and rivers just minutes away. Competitive hourly rate and excellent benefits package. Contact Therese O'Brien, Tyler & Company, 9040 Roswell Road, Suite 550, Atlanta GA 30350, (404) 641-6408.

WILLIAMSBURG VA—Unusual opportunity for BC/BE Family Practitioner to take over busy practice with two other BC Family Physicians. Send CV to: Cliff Henderson, MD, Williamsburg VA 23185; or call 1-804-220-2236 or 804-229-2546.

GRAND CAYMAN PARADISE—Luxury condo on Seven Mile Caribbean Beach, includes tennis court, bicycles, 2 pools, Jacuzzi, and Sunfish at the beach. 2-bedroom unit, last 2 weeks of August at $1000/week or $1800 both weeks. 3-bedroom unit, last 2 weeks of July, $1200/week or $2200 both weeks. Scuba, snorkel, sailing, fishing, golf all nearby. Dr. Jay Buston, 804-266-7613 or 804-272-7849.

PRACTICE OPPORTUNITIES in Virginia—Excellent professional and lifestyle opportunity in southeastern Virginia. Sentara Health Plan, a staff model HMO, is seeking BE/BC Family Practice, Internal Medicine and Pediatric physicians. We are a subsidiary of Sentara Health System, the largest and most comprehensive health care network in Virginia, and are also affiliated with major teaching and community hospitals. Sentara Health Plan physicians practice at seven conveniently located Health Centers and admit patients to leading area hospitals. Outstanding cultural, educational and recreational activities. Competitive salary, benefits and incentive plan. Contact: Helen Clendenin, 22 Koger Executive Center, Suite 125, Norfolk, Virginia 23502 or call collect (804) 466-0712. An Equal Opportunity Employer.

HOLTER RECORDERS provided to physician's offices at no charge. Virginia Heart Institute's services includes scanning, analysis and interpretation of Holter 24-hour ambulatory recordings. Call 804-359-9265 or in Virginia 1-800-468-1030.

WINTERGREEN RENTAL—Cliffs Condominiums, two bedroom, two bath, overlooking entire Wintergreen village near top of the expert slope. Rates are substantially less than through Wintergreen's front desk. Call Thomas Shuttleworth at 804-431-3100 or write 2809 S. Lynnhaven Road, Virginia Beach VA 23452.

APPRAISALS & SALES—The specialists in on-site practice valuations and transfers to physicians, hospitals and investors. Please contact: Ed Strogen, Fulton, Longshore & Associates, Inc., 527 Plymouth Road, Suite 410, Plymouth Meeting PA 19462; 215-834-6780 or 1-800-346-8397.

NATIONAL CAPITOL SYSTEMS, INC.

5205 Leesburg Pike
Suite 400
Falls Church, VA 22041
(703) 671-3360

is actively recruiting
Correctional Facility
Health Care Professionals

- Physicians
- Physician Assistants
- Registered Nurses
- Licensed Practical Nurses

NCSI is an expanding, financially sound, mid-sized, diversified firm. Contracts are primarily in health services and automated systems. Health care professionals in many specialties are needed. Women and minorities are encouraged to apply. EOE

FARMVILLE, Virginia—Seeking full-time and part-time physicians for hospital located 1 hour west of Richmond. Excellent compensation, full malpractice insurance coverage, and benefit package to full-time staff. Contact: Betty Albrecht, Emergency Consultants, Inc., 2240 S. Airport Road, Room 40, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

OB-GYN Physician, Shenandoah Valley–Four physician practice is seeking a physician to associate with them in an active OB-GYN practice utilizing a modern progressive community hospital. Enjoy the advantages of the University Medical Center within 25 miles. Live in the beautiful Shenandoah Valley and share a great call schedule that will allow you to take full advantage of the abundant opportunities offered in this area. Send CV to: OB-GYN Associates of Waynesboro, Inc., 428 S. Magnolia Avenue, Waynesboro VA 22980. Phone: 703-942-1214.

RICHMOND, Virginia—Seeking residency-trained physicians for full-time and part-time emergency department opportunities. Two facilities with a combined patient volume of 50,000 plus provides excellent medical and surgical back-up. Double coverage provided during peak periods. Excellent compensation and paid malpractice insurance. Benefit package available for full-time physicians. For more information contact: Betty Albrecht, Emergency Consultants, Inc., 2240 S. Airport Road, Room 40, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

PHYSICIANS
Come Grow With Us

We are looking for physicians in:

*ORTHOPEDICS
*PEDIATRICS
*FAMILY PRACTICE
*EMERGENCY MEDICINE

Guaranteed salary, free office space, relocation expenses and malpractice assistance await your arrival to one of the best kept secrets in the State. Direct all inquiries to James Bryan, Administrator.

JEFFERSON MEMORIAL HOSPITAL

P. O. Box 1228 Charles Town, WV 25414

(304) 725-3411 Ext. 210

60 minutes from D.C.
15 minutes from Virginia, Maryland

DIRECTORY OF ADVERTISERS

Clements & Company 99
Cumberland Hospital for Children and Adolescents 133
Health of Virginia 117
Integrated Office Solutions, Inc. 125
Jefferson Memorial Hospital 135
Lewis-Gale Clinic, Inc. 113
Eli Lilly & Company 130
Medical Protective Company 95
National Capitol Systems, Inc. 134
Palisades Pharmaceuticals 124
John P. Pearl & Associates ..... Cov 2
Peoples Drug Stores 90
Reed and Carnrick 89
Richmond Headache Center 99
Roche Laboratories 127-128
Saint Albans Psychiatric Hospital 96
Sentient Systems, Inc. 85
University Center for Addictive Behavior 87
United States Army (Active) ..... Cov. 3
United States Army (Reserve) 129
Virginia Insurance Reciprocal 122-123

MOVING?
We need to know!

Notify VIRGINIA MEDICAL immediately.

Please attach your mailing label here.

Name _____

New address _____

City _____ Zip _____

State _____

Mail to: VIRGINIA MEDICAL
4205 Dover Road
Richmond, VA 23221

WHO'S WHO

Dr. Anas M. El-Mahdi, chairman of the Department of Radiation Oncology and Biophysics at Eastern Virginia Medical School, is to be the recipient of the medical staff award for outstanding contributions to medicine at the Obici Hospital's 37th annual conference on April 4 in Suffolk. An Egyptian by birth, Dr. El-Mahdi earned his MD degree at Cairo University (1959) and a doctorate in science at Johns Hopkins University (1970). He is a fellow of the American College of Radiology, belongs to numerous national societies relevant to the sciences, and has published in excess of 175 cancer-related articles in medical journals in this country and abroad.

For his leadership in wildlife conservation in Virginia, a portrait of **Dr. William A. Pennington** has been given a place of honor in the Virginia Wildlife Federation's headquarters in Virginia Beach. The Buckingham County physician and former Virginia legislator helped organize the Buckingham Game Conservation Club in 1947; a year later, when the club became an arm of the National Wildlife Federation, he became the statewide organization's first president. Today the VWF has a membership of 16,000, and Dr. Pennington is on its board of directors.

Fellowship in the American College of Surgeons was conferred on **Dr. William E. Broach III**, Danville, at the College's 1989 clinical congress.

And a Danville nephrologist, **Dr. Michael A. Moore**, has been elected to a fellowship in the Council on Hypertension Research for the American Heart Association. As a representative of the AHA, Dr. Moore chairs the National Institute of Health's High Blood Pressure Education Coordinating Committee.

For "outstanding contributions, both to the professional world and to the community as a whole," **Dr. Susan J. Mellette,** Richmond, was named 1989 Professional of the Year by the Virginia Association of Professions. Dr. Mellette is professor of oncology at the Medical College of Virginia and head of the school's cancer rehabilitation program.

Dr. H. Joseph Williams, family physician in Staunton, was one of five persons designated winners of the 1989 Distinguished Service Awards of the National Interscholastic Athletic Administrators Association. The awards were presented in December at a meeting of the NIAAA in Dallas, where Dr. Williams was praised for his 40 years as team physician for the football and basketball teams of Staunton's Robert E. Lee High School. The 1989-90 basketball season will be his swan song on the athletic field, Dr. Williams says, although at 72 he's still up for private practice.

Two Medical Society of Virginia members received distinguished faculty awards from Virginia Commonwealth University during the university's annual convocation last month. They are **Dr. Leo J. Dunn**, chairman of the department of obstetrics and gynecology at the Medical College of Virginia, who was given the Distinguished Service Award, and **Dr. Hyung Mo Lee**, MCV's chairman of vascular and transplantation surgery, who received the University Award for Excellence.

Dr. Russell D. Evett, MSV councilor for the 2nd district, went back to med school recently as the Medical Society of Virginia's emissary to the scholarship recognition ceremony at Eastern Virginia Medical School. He is shown above, flanked by the two EVMS students who shared the Society's scholarship. They are Maria Tabora (M-92), left, and Jacqueline Henderson (M-92). Dr. Evett's alma mater, the Medical College of Virginia/VCU, also received MSV scholarship money, and so did the University of Virginia School of Medicine.

Photo courtesy Eastern Virginia Medical School

FAMILY PRACTICE. A REWARDING EXPERIENCE IN ARMY MEDICINE.

The Army has more soldiers with families than ever before. So when you join the Army Medical Team as a Family Practitioner, expect to spend most of your time serving not only soldiers, but their spouses and children, too. What's more, you won't have to worry about the paperwork, malpractice insurance premiums, or the costs incurred in running a private practice.

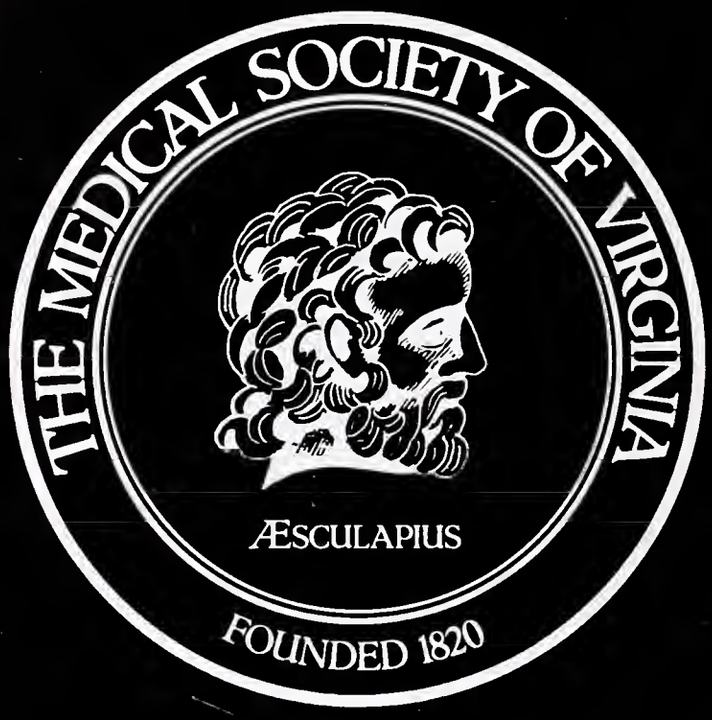
Expect to work in a highly challenging and varied environment. Working with a team of highly trained professionals, you can receive assignments almost anywhere in the United States; the Army offers the largest system of comprehensive health care in the nation. Family Practice positions are also available overseas, in Germany and Korea.

The benefits package available to Army Family Practitioners is quite attractive. You'll receive 30 days paid vacation, opportunities to continue education and conduct research, a chance to travel, and reasonable work hours.

All in all, your Army Family Practice will be a rewarding experience. Not only for you, but for Army families, too. Talk to your Army Medical Department Counselor for more information.

ARMY HEALTH CARE TEAM
Federal Office Building
400 North 8th Street
PO Box 10167
Richmond VA 23240-0167
(804) 771-2354

ARMY MEDICINE. BE ALL YOU CAN BE.



In the wake of deunification, 350 Virginia physicians signed on for MSV membership. Their names are on pages 94-101 of this issue.

VIRGINIA MEDICAL

CURRENT
JNLS
W1
V1
799J

Virginia Medical
UCSF LIBRARY
Received on: 04-20-90

APR
1990

The Award Winning Publication of The Medical Society of Virginia

WASTE DISPOSAL
How to handle the new regulations

GENERAL SURGEONS: BROADEN YOUR EXPERIENCE.

Your time and talent are valuable. They're valuable to the Army Reserve, too. We'll pay you for a small fraction of your time, not only in money, but with big opportunities and challenges you won't find in civilian practice.

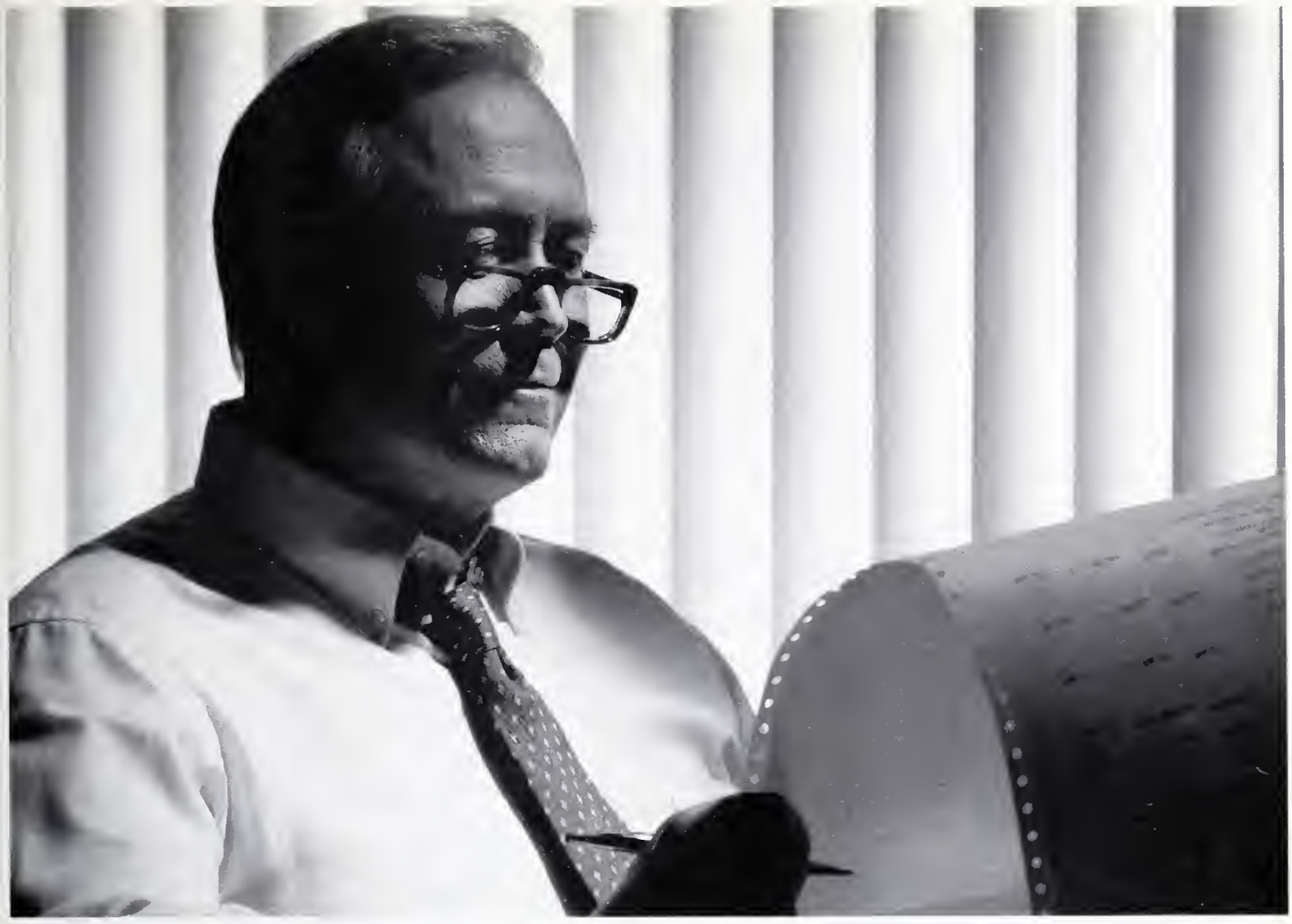
- You'll have flexibility in how and when you participate.
- You'll be offered conferences and continuing education.
- You'll have opportunities for military training in areas like Advanced Trauma Life Support, Parachuting, Flight Medicine and Mountaineering.
- You'll work with top, dedicated professionals.
- You'll have the rank and privileges of an Army officer.

If you want more information about the Army Reserve, or if you would like to talk to an Army Reserve physician, our experienced Army Medical Counselors can assist you. Call collect or write:

Major Wayne S. Young
P. O. Box 10165
Richmond, Virginia 23240-0165
804-771-2401

BE ALL YOU CAN BE.®

ARMY RESERVE



Three financial reasons why practices choose the ACCLAIM™ Medical System

There are many compelling reasons to automate with the ACCLAIM Medical System. Here are three important benefits our customers have taken the time to write to us about:

1 Improved Cash Flow

"We have seen dramatic improvements in the efficiency of filing insurance claims and tracking accounts. We've also seen substantial improvement in our accounts receivable."

Susan Shaffer, Office Manager
Single Physician Practice

2 Increased Productivity

"The system is easy to use, straightforward in its commands and simplifies medical office management beyond belief."

Judy Greenburg, Office Manager
Four Physician Practice

3 Financial Control

"Sentient's ACCLAIM system has improved our collections by 100% and has provided reliable data on which to base practice management decisions."

Frank J. Mayo, M.D., Pulmonologist

Sentient Systems offers total solutions. Hardware (IBM® and compatible), software, installation, data conversion, training, support and service are a part of every system. We provide the highest quality medical system available today. Just ask our customers.

For a free consultation call Sentient at:

301-929-7600
800-247-9419

ACCLAIM is a trademark of Sentient Systems, Inc.
IBM is a registered trademark of International Business Machines Corporation.

I'm interested. Please...

☐ Rush me an information portfolio.
☐ Call to set up a free office analysis.

I plan to purchase within:

1 month ___ 2 months ___ 3-6 months ___

Practice Name

Address

City State Zip

Telephone Best time to call

Return to: Sentient Systems
10410 North Kensington Parkway
Kensington, MD 20895-2939

SENTIENT
SYSTEMS

THE MEDICAL COMPUTING LEADER

VIRGINIA MEDICAL

April 1990, Volume 117, Number 4

© 1990—The Medical Society of Virginia

ON THE COVER

144 **Waste Disposal: How to Handle the New Regulations. . .'No Knocking on MD's Doors' for Enforcement. . .The Governor's Waste Management Team. . . Who's Who in Waste Handling in Virginia. . .It's Worse in New Jersey**
John H. Keene and Ann Gray

SPECIAL ARTICLE

152 **House Dust Mites in Williamsburg, Virginia**
Mark T. Lassiter and Norman J. Fashing

MEDICINE

160 **Ehrlichiosis in Virginia: Case Reports**
Milton Ende, P. M. O'Donnal, Frederick I. Ende, and Mark Ende

162 **Abstracts from the Annual Meeting of the Virginia Surgical Society**

POINT OF VIEW

165 **The Case for Economy Class**
Juan M. Montero, II

EDITORIALS

166 **The Price of Regulating** Raymond S. Brown

166 **The State Board of Medicine** E. L. Kendig, Jr.

141 **Letters to the Editor**

167 **Medical Society of Virginia Officers**

168 **Obituary**

174 **Meetings about Medicine**

177 **Classified Advertisements**

178 **Directory of Advertisers**

Editor	Edwin L. Kendig, Jr., MD
Associate Editors	Richard G. Lester, MD; Duncan S. Owen, Jr., MD; John A. Owen, Jr., MD
Editorial Board	H. C. Alexander III, MD; Raymond S. Brown, MD; Henry S. Campell, MD; C. Barrie Cook, MD; Eloise C. Haun, MD; Walter Lawrence, Jr., MD; Lockhart B. McGuire, MD; Robert Edgar Mitchell, Jr., MD
Executive Editor	Ann Gray
Business Manager	James L. Moore, Jr.

DISCLAIMER: Advertisements in VIRGINIA MEDICAL for products, services, courses and symposia are published with a "buyer beware" understanding. The Publisher, the Editor and members of the Editorial Board do not imply warranty of products, nor endorsement of offered educational material.

VIRGINIA MEDICAL (ISSN 0146-3616) is the monthly publication of The Medical Society of Virginia. Second-class postage paid at Richmond, Virginia. Yearly subscription rate: $24 domestic, $30 foreign; single copies, $3. VIRGINIA MEDICAL does not hold itself responsible for statements made by any contributor. The publisher reserves the right to reject any advertisement. For information on the preparation of articles, write to the Executive Editor for "Advice to Authors," or call (804) 353-2721. POSTMASTER: Send address changes to VIRGINIA MEDICAL, 4205 Dover Road, Richmond VA 23221.

Providing special services for senior citizens is our way of letting them know they're special.

At Peoples Drug, we offer everyone over sixty a 10% discount on prescriptions. We also offer an extensive selection of money-saving generic drugs, the extra service of Braille prescription labeling and free Health Care Pamphlets.

We provide all these special benefits to our older customers because it's our way of letting them know they're special. And of thanking them for being some of our best customers for such a long time.

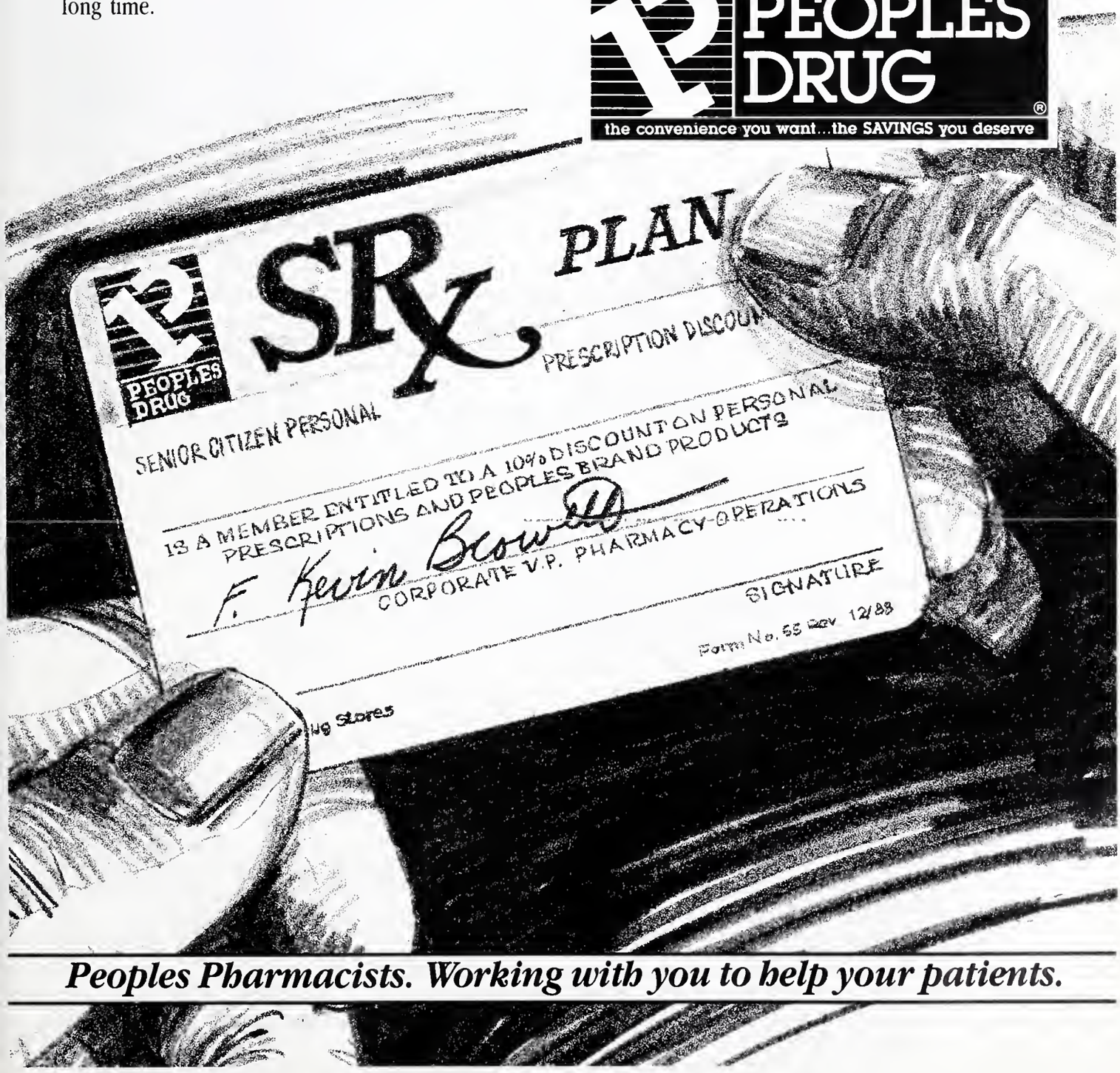
It's just another example of how — for over 80 years — Peoples Drug has served its customers with unmatched care and professionalism.

Today, all our services reflect our continuing commitment to meeting the changing needs of *your* patients. . .who become *our* customers.

No matter what their ages are.

PEOPLES DRUG®

the convenience you want...the SAVINGS you deserve



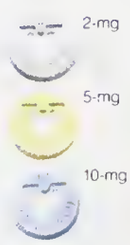
Peoples Pharmacists. Working with you to help your patients.

The practice is yours.
The patients are yours.
The prescriptions are yours.

Make the prescribing decision yours, too.

Sign on the right on
the "Dispense as written" line.

Specify VALIUM® brand of diazepam/Roche®



scored tablets

The cut out "V" design is a registered trademark of Roche Products Inc

The one you know best.

Copyright © 1988 by Roche Products Inc
All rights reserved

ROCHE Roche Products

Roche Products Inc
Manati, Puerto Rico 00701

LETTERS

Automated CBC count may obscure L-tryptophan toxicity diagnosis

L-tryptophan toxicity is now an established syndrome. Here is a summary case report to add to that of Dr. Becker et al:[1]

A 58-year-old white female was seen initially in the office on November 10, 1989, cyanotic, dyspneic and appeared near death. Chest x-ray was compatible with acute respiratory distress syndrome. She was immediately hospitalized and initial blood gases had astonishing findings of pH of 7.49; pCO_2, 31; pO_2, 27; with initial blood count of 15,400, segments 80%, bands 4% and lymphs 10%. No eosinophils were reported. The patient had to be intubated. The dramatic report of L-tryptophan toxicity appeared in the local newspaper that weekend and because of this the lab work was reviewed. The error on my part was forgetting that in automated counting of a CBC, esosinophils are not counted. Knowing the patient had peculiar eating habits (once she asked me to give her weight-reducing pills when she weighed only 85 lbs), I questioned her on the respirator and learned she was taking 10 grams of L-trypotophan a day. I then requested a total eosinophil count and a differential count done by hand. This confirmed the diagnosis. The total eosinophil count was 1,513 and a WBC of 14,500, normal count being 400. With this information the patient was started on large doses of IV steroids, with remarkable clearing of a puzzling lung diagnosis, and she was quickly restored to normal health.

Because of automated counting it is probable that many cases of L-tryptophan toxicity have been missed.

Milton Ende, MD

121 South Market Street
Petersburg VA 23803

1. Becker DM, Habib-Hong S, Smith SM. Eosinophilia and myalgia associated with L-tryptophan use: case report. Va Med 1990;117:68–70

Dr. Becker comments: Dr. Ende makes an important point. Most hospitals rely on automated CBC analyzers that can only estimate the WBC differential by noting variations in WBC size; thus in most hospitals an accurate WBC differential must be done manually, usually with special stains, such as peroxidase. However, there are machines that can automate the staining process and count thousands of WBCs in order to provide an accurate WBC differential from which an eosinophil count can be reliably estimated. In any case, an eosinophil count is indicated for all patients with unexplained myalgia, myopathy, neuropathy, or pneumonitis, and knowledge of L-tryptophan use should lead directly to this test.

Help available to doctors/parents involved in parental placement adoptions

The 1989 General Assembly passed changes in the parental placement adoption laws. These changes were intended to protect the interests of all parties in parental placement adoptions. One of the new requirements in the law is that birth mothers be offered counseling about the adoption decision and other options. In addition, home studies are required to be performed by licensed child placement agencies, either public or private. Public agencies have indicated that they may not be able to perform these studies because of their present case loads.

Children's Home Society of Virginia has been serving the needs of birth mothers, children and adoptive families for 90 years. The Society, a non-profit, nonsectarian agency, has professional staff to respond to the rising demand for these services throughout the state and is prepared to work with all interested parties for better understanding of these new requirements. In addition, Children's Home Society will work with local groups to conduct workshops on the process of adoption.

Should physicians have any questions regarding the new requirements for parental placement, they should call Mr. Peter Pufki, Executive Director, or Ms. Lois Gibbs, Child Placement Supervisor, at Children's Home Society of Virginia, 804-353-0191.

Grayson A. Harding

President,
Children's Home Society of Virginia
4200 Fitzhugh Avenue, Richmond VA 23230

In praise of John Lynch, "inspiring and dedicated leader"

On the morning of July 16, 1989, in the presence of his family at St. Luke's Hospital, John Phillip Lynch "fell on sleep and was gathered unto his fathers." The aphorism that "life may be and was meant to be an immortal youth" seemed well nigh to reach its complete fulfillment in the life history of Dr. Lynch.

Over 100 physicians associated with the McGuire Clinic formed the avant garde of medicine in Richmond. At their forefront John Lynch served as an inspiring and dedicated leader in the advancement of health sciences and especially medicine and nursing. While the practice of medicine has been radically affected by the government asserting its influence, Dr. Lynch and his associates held unswervingly to the

traditional relationship between patient and physician and maintenance of the highest standards of professionalism in resistance to bureaucracy and the rigidity of standardization.

Dr. Lynch's record of community service was exemplary. In the 1950s he served the Richmond Urban League as a member of the board during its trying time following the transition of Richmond from a rural community to an industrial and urban center. He was heavily involved in organization and legislation governing the nursing profession and became consultant to the Governor's Council on Nursing in 1968-1969. To the St. Luke's Hospital School of Nursing, which has produced nearly 1,000 alumnae, John Lynch contributed unstintingly his tutelage, inspiration, and direction. A pioneer in the quest for quality of care in nursing homes, rehabilitation of the disabled, and legislation favoring older workers, he contributed in an advisory capacity to a number of Richmond hospitals, nursing homes, and rehabilitation centers, lending the knowledge and expertise of nearly 50 years of active and widely acclaimed involvement in medicine. He was the first chairman of the Gerontology Committee of the Richmond Area Community Council and chairman of the Committee on Aging of the Medical Society of Virginia from 1979 to 1984. He was a committed member of the First Presbyterian Church, serving as an elder, and was cochairman of the Committee on Christianity and Health, Hanover Presbytery, Presbyterian Church of the United States.

Dr. Lynch's philosophy, ideas, and ideals have permeated our society, and so he will continue to be with us and live on in our minds and our hearts.

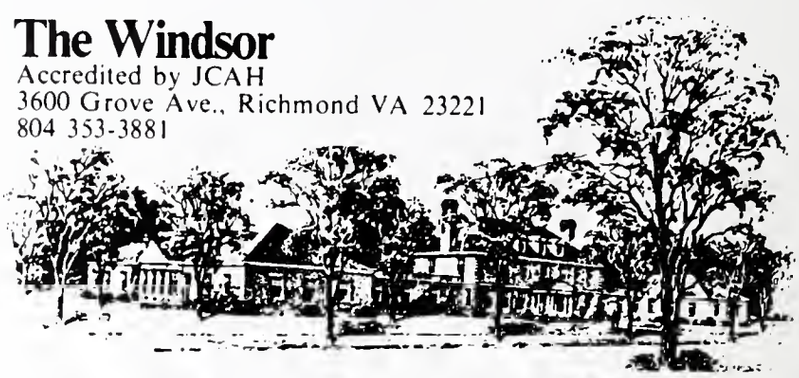
Walter W. Regirer

President, Health of Virginia
2420 Pemberton Road
Richmond VA 23233-2099

Editors' Note: For another tribute to Dr. Lynch, see the Obituary columns on page 169.

LONG-TERM CARE: IN SIXTH DECADE OF EXCELLENCE

The Windsor
Accredited by JCAH
3600 Grove Ave., Richmond VA 23221
804 353-3881



Mrs. Plyler's
Residential Care
1615 Grove Ave., Richmond VA 23220
804 353-3981

University Park
Accredited by JCAH
2420 Pemberton Rd., Richmond VA 23233
804 747-9200

ANNOUNCING

The NEW Individual Non-Cancellable Disability Program

Endorsed by
Medical Society of Virginia

- **Guaranteed renewable**
- **Level premiums**
- **Long term benefits**
- **Premium discount to MSV members**
- **No group increases**
- **Pays for total and partial disability and/ or loss of income**
- **Liberal underwriting**

ENROLL IN YOUR NEW ASSOCIATION PLAN NOW!

For information call
John P. Pearl & Associates, Ltd.
(804) 282-9600 or 1-800-572-2211 or mail the coupon below

Please send me more information on the MSV endorsed Non-Cancellable Disability Program.

Name _____

Address _____

City _____ State _____ ZIP _____

Birthdate _____ Phone _____

Best time to call _____

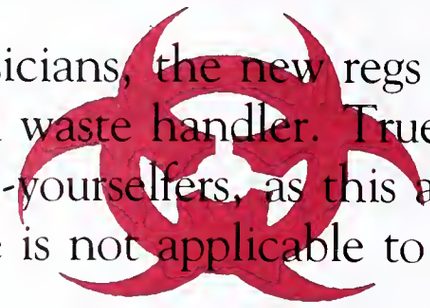
MSV/900230/3-90

Mail to:

John P. Pearl & Associates, Ltd.
6620 W. Broad St., Suite 300
Richmond, VA 23230-1724

Waste Disposal:
How to Handle the New Regulations

For many physicians, the new regs will add up to a contract with a waste handler. True, the regulations provide for do-it-yourselfers, as this article sets forth, but this route is not applicable to all practices.



POISED to go into effect on Tuesday, May 2, are Virginia's new Infectious Waste Management Regulations, which define infectious waste and stipulate specific requirements for its collection, transport, treatment and disposal. Thus is the State of Virginia responding to the recent hullabaloo when medical items washed up on New Jersey beaches. Congress rushed to pass the Medical Tracking Act; the states are following up with regulations. It makes no matter that those New Jersey beach items were never proven to be infectious. What matters is that the public *perceives* such waste as infectious. That perception is what state officials are trying to grapple with.

What Virginia's new regulations give physicians to grapple with are a long list of items defined as infectious and rigorous packaging/treatment/disposal specifications for that waste. For many physicians, this will add up to a contract with a commercial waste handler and a corresponding hike in office overhead. True, the regulations provide for do-it-yourselfers, as this article sets forth, but this route takes some doing and is otherwise not applicable to all practices.

In any case, it is important to know exactly what the regulations say and mean so that you can evaluate intelligently the solicitations of waste handlers and comply with the regulations in the most cost-effective manner.

The Waste

The regulations stipulate that waste defined as infectious (Table 1) must be handled as follows:

1) Infectious waste cannot be placed in a landfill without undergoing treatment to render it non-infectious.

2) The stipulated treatment is either incineration or steam steriliza

See related editorial, page 166.

tion. No other treatment will be considered acceptable except by special approval of the director of Virginia's Department of Waste Management.

It should be noted that the regulations exclude certain items from the infectious designation. They appear in Table 2.

The Generator

The regulations apply to "all persons who generate infectious wastes; own or operate infectious waste management facilities or allow infectious waste management facilities to be operated on their property in this Commonwealth . . . except those specifically exempted or excluded elsewhere in these Regulations."

Since physicians generate wastes defined by the regulations as infectious, they are subject to compliance. As the generator, the physician is responsible for the appropriate packaging and labeling of that waste and cannot delegate this task to a contractor or other agent.

From other requirements involving transport and treatment, however, the physician-generator may qualify for money-saving exemptions, as follows.

Exemptions

According to Section 3.1.E, the regulations do not apply to health care professionals who generate waste defined as infectious in the provision of services in their own offices or in the private homes of patients, provided the waste is disposed of as specified:

1. With respect to defined infectious waste other than sharps, if the practitioner accumulates no more than 64 gallons of waste, packages it as required (see Packaging/Labeling below), and delivers it within 14 days to a permitted infectious waste storage or treatment facility, as defined by Section 3.1.E.3, that practitioner is exempted from all other sections of the regulations.

This article and accompanying information were developed jointly by John H. Keene, DrPH, and Ann Gray. Dr. Keene is president of Biohaztec Associates, a biosafety consulting firm at 924 Castle Hollow Road, Midlothian VA 23113. Mrs. Gray is executive editor of Virginia Medical.

As a service to Medical Society of Virginia members, most of the information published here was preprinted in newsletter format and mailed early last month.

2. With respect to sharps, if the sharps are packaged in rigid, leakproof and puncture-resistant containers, are labeled as required, and are transported to a permitted waste treatment or storage facility, the practitioner is exempted from all other requirements of the regulations.

3. With respect to transporting either or both of the above, if the physician or one of his/her employees transports the packaged/labeled waste to a treatment or storage facility, the material becomes exempt from Section 4.2.B.4, which requires that the material be additionally contained in a rigid, double-walled, corrugated fiberboard box.

If, however, the physician hires a waste hauler to do the transporting, the boxing requirements of Section 4.2.B.4 apply, with the attendant labor and costs.

Table 1. Waste Defined by the Regulations as Infectious and Subject to Control.

1. Cultures and stocks of microorganisms and biologicals. Discarded cultures, stocks, specimens, vaccines and associated items likely to have been contaminated by them.
2. Blood and blood products (free-flowing blood).
3. Pathological wastes.
4. Sharps—hypodermic needles, syringes, scalpel blades, Pasteur pipettes, broken glass, etc.
5. Animal carcasses, body parts, bedding and related wastes when animals have been deliberately infected with organisms likely to cause disease in healthy humans.
6. Residues or contaminated soil, water or other debris resulting from the cleanup of a spill of infectious waste.
7. Any waste contaminated by or mixed with infectious waste.

Table 2. Items Excluded from the Regulations.

1. Used products for personal hygiene (i.e., diapers, facial tissues and sanitary napkins).
2. Materials, not including sharps, containing small amounts of blood or body fluids but no free-flowing or unabsorbed liquid.

Controlling Costs

What else can physicians do to minimize the economic impact of these new regulations? Here are some possibilities.

Auditing the Waste

Wastes not defined as infectious, i.e., "normal" wastes, need not be treated and may be disposed of in the conventional way. Accordingly, this non-infectious waste should be carefully segregated so that it does not add to the burden and cost of disposing of the infectious wastes.

For the removal, transport, treatment, and disposal of infectious material, the waste handler will charge by the pound and, because of the presumed hazard level, at a premium rate. Accordingly, the generation of this waste should be kept at a minimum.

A review of Tables 1 and 2 will identify the quantity and types of wastes being generated within a time period, so that an infectious waste control plan for the practice can be developed.

Segregating the Waste

Throughout the office, provide two containers for waste disposal, one for regulated waste, the other for non-regulated, or normal, refuse. All office personnel must be thoroughly informed as to the identification of regulated waste and the method for segregating it.

Packaging/Labeling the Waste

As noted above, the regulations make perfectly clear that the physician-generator of infectious wastes is responsible for the appropriate packaging and labeling of that waste; the responsibility for any portion of the procedure cannot be delegated to a contractor or other agent who is providing services to the generator. This applies whether or not the physician-generator is exempt from other parts of the regulations.

Further, the packaging and labeling must be performed in compliance with Section 4.2 of the regulations as follows:

1. All liquids must be contained in sturdy leakproof containers that resist breaking.
2. Sharps must be collected at the point of generation in puncture-resistant containers.
3. The above waste and all other regulated infectious waste (Table 1) must be contained either
   - in two leak-proof plastic bags (i.e., double-bagged), each bag capable of passing the ASTM 125-lb drop-weight test and each sealed separately, or

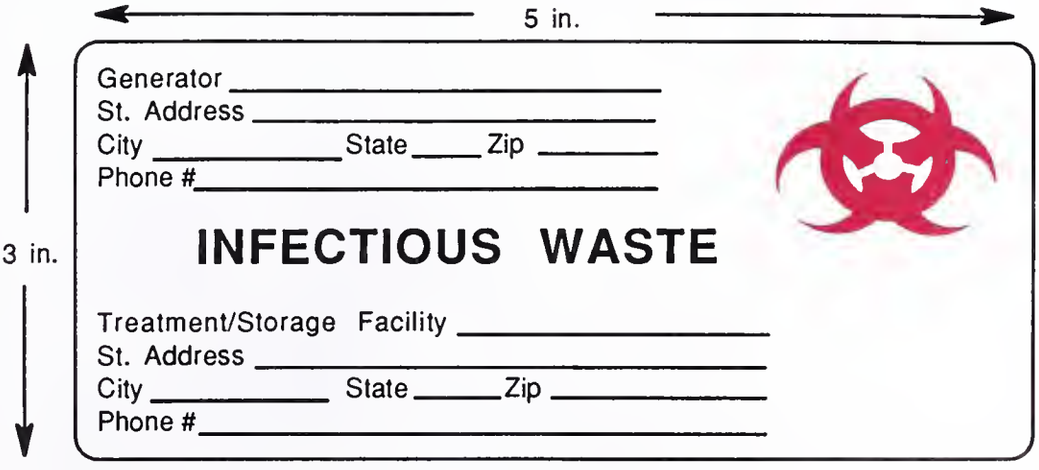


Fig. 1. Infectious waste label. Biohazard symbol must be printed in red.

Enforcement: 'No Knocking on MDs Doors'

Regulations by a state agency empowered by Virginia's General Assembly have the force of law, and the new Infectious Waste Regulations fit that category. Thus any intentional violation can be prosecuted as a felony, and civil penalties can also be assessed, according to Robert Wickline, environmental engineer with the Department of Waste Management, who has been designated to head up implementation of the new regs.

Asked about policing mechanisms, Wickline said he had planned to add a couple of persons to the department's enforcement staff, but the current budgetary crunch had wiped out that idea and he will borrow staff from the solid waste area. In any event, he emphasized, "There won't be anybody going around knocking on doctors' doors or anything like that." Instead, enforcement will focus on the waste handlers' operations.

Wickline is aware that doctors are bearing an increasing burden of regulations. He feels that physicians in urban areas will be able to adjust fairly readily to the new infectious waste strictures, but he expressed concern about physicians in rural areas, where waste handlers may impose higher prices for collection. "We haven't figured out a way to help them yet, but we're trying," Wickline said. Meantime, he is in hope that local hospitals will provide some assistance.

The Governor's Waste Management Team

Director of the Virginia Department of Waste Management is Cynthia V. Bailey, who was appointed by former Gov. Gerald L. Baliles and reappointed by Gov. L. Douglas Wilder. A graduate of the University of Richmond School of Law, Director Bailey was an assistant attorney general during Baliles' term as Virginia's attorney general.

The seven members of the Department's Waste Management Board are also appointed by the governor. They are selected for their expertise in areas pertinent to environmental issues. The current members are James R. Craig, PhD, Blacksburg, chairman; James A. Davis, PhD, Winchester; Edward I. Long, Lawrenceville; Michael Markels, Jr., PhD, Springfield; Joan MacCallum, Lynchburg; Frank H. Miller, Jr., Hampton; and Heather Wicke, PhD, Arlington.

- in one leakproof plastic bag inside a double-walled corrugated fiberboard box or equivalent rigid container meeting Department of Transportation standards.

4. For the waste that is to be steam sterilized, the plastic bags must be orange in color. They must be marked with autoclave tape. Waste destined for incineration must be placed in bags that are red in color.

5. All bags must be sealed against all possibility of leakage by lapping the gathered open end and binding with tape or a closing device.

6. If the waste is to be transported to a storage or treatment facility by a waste hauler, the plastic bags must be enclosed in a double-walled, corrugated fiberboard box as described above.

7. Figure 1 shows a sample label. Note that it is 3×5 inches in size, that the name/address/phone number of both the generator and the person or facility to whom control of the waste is being transferred are given, that the words "infectious waste" are in large, bold type, and the universal symbol for biohazards appears on the label in red. All this must be printed in indelible ink.

It is up to the physician to acquire all the packaging/labeling supplies specified above. A medical supply house may be the resource for sharps containers. The boxes may be procured from a waste handler. As for the label, you will probably want to have these printed especially for your use.

Treating the Waste

The regulations require steam sterilization of regulated infectious waste for a minimum of 90 minutes at 221° F at 15 pounds pressure. Thorough testing must be performed on the sterilizer and documentation kept for each load of waste sterilized. Documentation must include 1) date, time and operator of each run; 2) type and approximate amount of waste treated; 3) post-treatment reading of temperature-sensitive tape; 4) dates and results of calibration of the sterilizer; and 5) results of

spore treating performed for the month in which sterilization is done.

In the unlikely event the physician has access to an autoclave of sufficient capacity and treats the bags of waste as specified, then the steam-treated waste is considered no longer infectious and may be disposed of as normal trash. The waste must be packaged in orange plastic bags as cited above, however, and the autoclave tape must indicate that the material has been sterilized. In addition, the physician-generator must have complete documentation on file for each treatment run.

Transporting the Waste

If, as is likely, the practitioner cannot treat the regulated infectious waste on-site, it must be transported to a storage or treatment facility. You will remember the first listed exemption above, allowing for the private transport of infectious waste by the physician or the physician's employees provided that 1) the volume of waste is less than 64 gallons; 2) it has been stored for no more than 14 days; and 3) it is properly packaged in plastic bags and duly labeled.

If, however, the waste is taken to a storage facility, the operator of that facility will have to box it for the trip to a treatment facility, and there will no doubt be some charge for this service.

Training the Staff

All personnel in the doctor's office must be informed as to the specific methods for identifying, segregating, treating (if it is done on-site), and transporting of infectious waste. Those involved in these procedures should understand thoroughly the potential hazards involved and be informed as to the appropriate methods for protecting themselves from exposure. It is also important to document that the employees have received the training and to update that training periodically.

Protecting the Plan

"If anything can go wrong, it will." It is important to have alternative plans for the transport and treatment of regulated waste in case something goes wrong. A hospital incinerator may no longer be available. What will you do? The employee assigned to take your waste to the storage facility gets sick and can't make the trip. Who will take it? Once your primary plan is developed, give it a long hard look and determine what problem areas might develop, then decide how you will handle the situation if something goes wrong.

The Cost: It's Worse in New Jersey

In his editorial on page 166, Dr. Raymond S. Brown chronicles the increased costs his practice has incurred in order to meet increasingly rigorous waste disposal mechanisms, specifically his group's higher waste handling tab. In New Jersey, doctors not only have the treatment/handling costs to contend with but are also subject to an annual fee laid on by the State Department of Environmental Protection. Originally, when New Jersey's new regulations were passed early in 1989, the fee was set at $528 for every waste generator in the state—including every physician-generator, but lobbyists for the Medical Society of New Jersey moved in on the legislature, and the following schedule of maximum charges was substituted: Under 50 lbs/yr, $100; 50-200 lbs/yr, $300; over 200-300 lbs/yr, $500; over 300-1000 lbs/yr, $1000; over 1000 lbs/yr, $3500.

Who's Who in Waste Handling in Virginia

Three waste handlers account for most of the medical waste disposal in Virginia: Browning Ferris Industries, Waste Management, Inc., and Incendere, Inc. BFI and WMI are huge national firms, veterans of the waste disposal business. Incendere is a new firm headquartered in Norfolk, the only one of the three with its own treatment facility in Virginia.

- BFI's headquarters are in Houston, Texas. It has nine operating locations in Virginia, and its familiar blue trucks with the BFI logo will go anywhere in the state to collect medical waste, its representatives say. For details, call the Richmond office at 804-222-7070.
- WMI, which is headquartered in Oak Brook, Illinois, previously operated only in Northern Virginia (Alexandria, Arlington, Fairfax Counties) but is moving further into the state by setting up offices in Richmond, Norfolk, Newport News and Petersburg. For details, call the regional office in Charlotte, North Carolina: 704-364-1039.
- Incendere was founded in 1986 in Norfolk by two enterprising Virginians, the brothers Elliott and Dwight Shaubach. This is a regional operation, with additional offices in Richmond, Philadelphia, and Lexington, South Carolina. Its Norfolk treatment facility is comprised of three 25-ton incinerators. For details, call 1-800-USA-BURN.

Spinal Cord Injuries

Head Trauma

Strokes

Amputations

Multiple sclerosis

We specialize in restoring independence.

CAMC's Rehabilitation Center has everything it takes to help the seriously disabled regain physical and psychological independence.

Physical therapists. Speech and language pathologists. Psychometricians. Prosthetists. *Every* therapy discipline is represented on our rehabilitation team. Board-certified physiatrists orchestrate each patient's personalized treatment plan, supported by our qualified nursing staff.

All treatment and technology are state-of-the-art. An independent living apartment for practicing home skills. Radiologic techniques to diagnose severe swallowing problems. A biofeedback lab to help patients manage pain and regain nerve function.

We also have one of the few adjustable ergonomic kitchens in the nation. And one of only two BTEs in the state. This Baltimore Technical Equipment enables patients to simulate many common tasks, like turning wheels and working with tools.

CAMC's Rehabilitation Center is the most comprehensive facility of its kind in West Virginia. Hospital-based, with the diversified tertiary care capabilities of CAMC as back-up.

You can refer your patients to us with confidence. And they'll return to you with confidence.

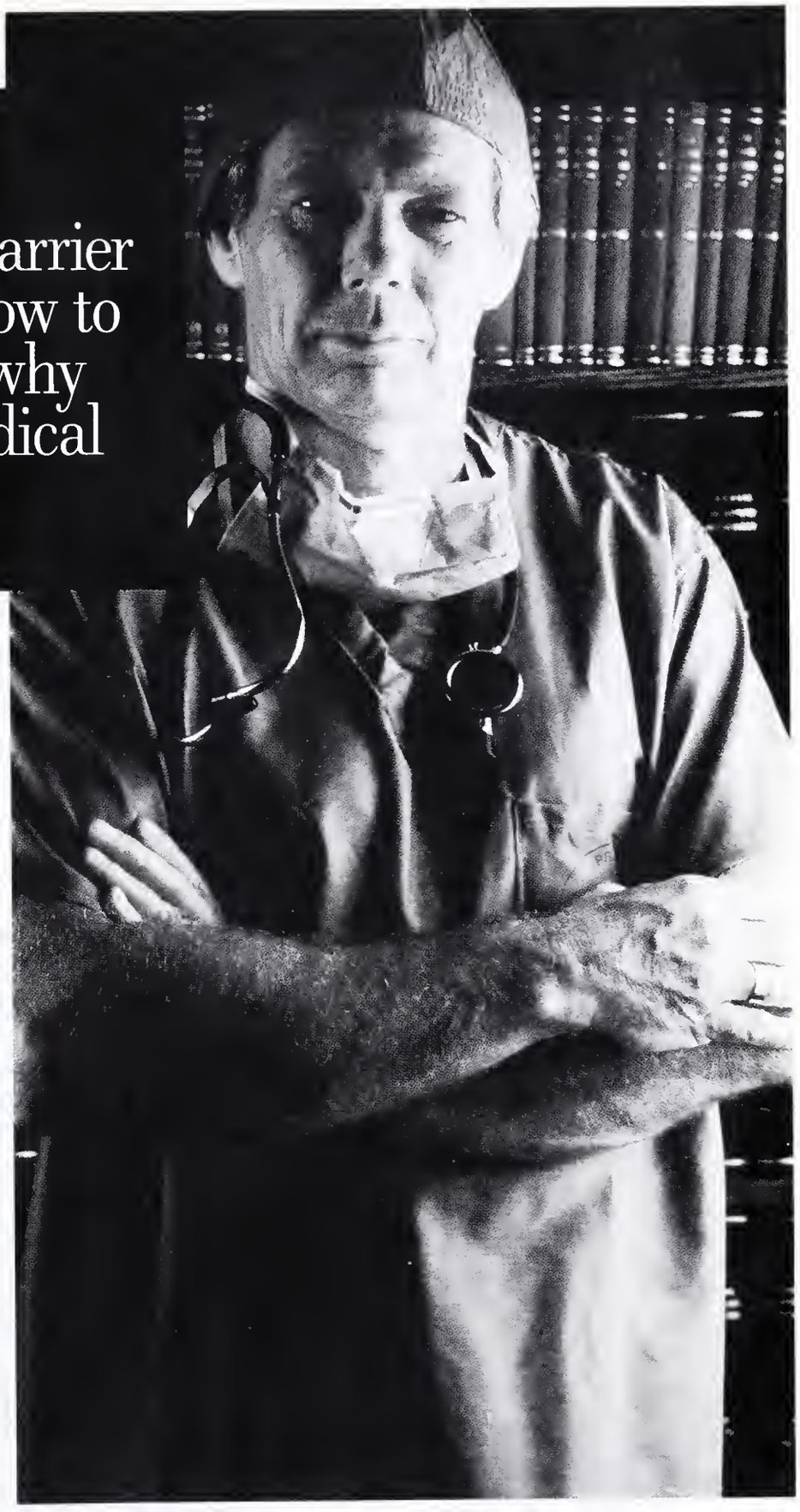
For more information and admission details, call 1-800-346-2272. Outside West Virginia, call collect 304-340-7733.

CAMC

Charleston Area Medical Center

P.O. Box 1547
Charleston, WV 25326

"I want a malpractice carrier that knows how to fight. That's why I'm with Medical Protective."



At Medical Protective, fighting for our doctors is our number one priority. We know we're not just insuring your finances. We're protecting your professional reputation, an asset no amount of insurance can replace.

And when we go to battle, our winning record is unsurpassed. The reasons are simple.

First, no one knows more about defending doctors than we do. We invented professional liability insurance 90 years ago and have been defending doctors ever since.

Second, since our inception we have employed only the most experienced and skilled malpractice lawyers in your area. We will never waver from this commitment.

Third, commitment of this kind requires financial strength and stability. With nearly a billion dollars in assets and a continuous A.M. Best A+ (Superior) rating, we don't have to make individual case decisions based on the bottom line. We have the financial clout to do whatever it takes to serve our doctors.

If you would like this kind of aggressive defense in your corner, don't wait. Call The Medical Protective Company General Agent in your area today.

THE
MEDICAL PROTECTIVE COMPANY

America's premier professional liability insurer.

Ted J. Pandak, David R. Fuller, Suite 205, 7275 Glen Forest Drive, Richmond, Virginia 23226, (804) 285-4151

Catastrophic Illness is Rare and the Treatment is Critical.

You know the patient. The one with chronic psychosis that hasn't responded to general inpatient care. The patient has comprehensive coverage so you've been able to admit him time and time again for inpatient care. But there's been little if any improvement, and you're frustrated. It's time to refer him to a hospital that is committed to treating the long term refractory patient and has the resources to do it. Sheppard Pratt.

Today's literature discourages long term hospitalization, and we agree. That same literature does, however acknowledge that a small group of chronic patients cannot be treated any other way. In 1984, Sheppard Pratt opened an 18 bed unit that treats only those types of patients.

We are not talking about custodial care nor do we treat patients who spend years talking about delusions. We provide long term, active, behavioral, psychopharmacological treatment for those patients who can genuinely be helped.

In addition to managing systematic and aggressive medication trials, our patients live within an established token economy. Patient education and social skills programming, and specialized activity therapy are provided daily throughout treatment. Formalized psychoeducation is also a vital component of treatment and family involvement. Comprehensive discharge planning is given attention equal to inpatient care. Sheppard Pratt provides many options for aftercare including a quarterway house, supervised housing, vocational training, outpatient therapy and medications management, and day hospitals.

Sheppard Pratt is a comprehensive network of psychiatric services. In addition to our 322 bed hospital we maintain the 16 bed Mt. Airy House, numerous community outreach programs and the National Center for Human Development. For more than 100 years, Sheppard Pratt has earned its reputation for providing quality care to the chronically ill patient. And during these difficult economic times, we remain loyal to that heritage.

For further information or to make a referral contact the Adult Admissions Office at:
(301) 938-3800
6501 North Charles Street
Baltimore, Maryland 21285-5815

▪ *Sheppard Pratt*
A not-for-profit health system

©1990 Sheppard Pratt

Do New Medical Malpractice Carriers Make You Nervous?

Some medical malpractice carriers offer a low price the first couple of years. After that, who knows?

We've been independent brokers for more than forty years and can offer competitive policies and premiums. We're not limited to an endorsed policy or exclusives required by many insurance carriers.

Find out about some **"A+"** companies who have established a track record. Save yourself some money.

We can advise you on the *best* policy for all your needs—from the *best* company at the *best* price. Frankly, we can handle all your professional and personal insurance needs, from office packages to auto coverages.

Call Clements and Company today for an "independent's approach" to buying medical malpractice insurance.

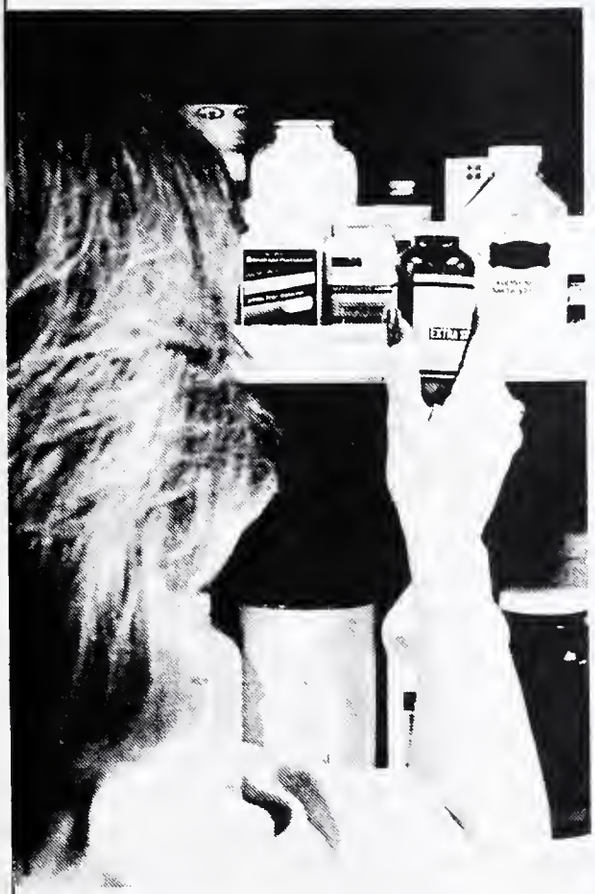
Clements and Company

Specialist in Medical Malpractice Insurance

Telephone: (202)872-0060 **Fax:** (202)466-9064

Telex: 64514 **Cable:** CLEMENTS/WASHINGTON

1730 K Street, NW, Suite 701, Washington, DC 20006



HEADACHE

THERE IS AN ALTERNATIVE

Headache is the most common disorder of modern man. It has been estimated that one out of three Americans suffers from severe headaches at one time or another.

The RICHMOND HEADACHE CENTER is a unique facility which specializes in the diagnosis and management of chronic and recurrent headaches.

The RICHMOND HEADACHE CENTER was founded by a group of practicing neurologists and clinical psychologists who recognized the need for a cooperative effort in treating chronic and recurrent headaches.

For more information, write or call .....

YES, please send me more information about RICHMOND HEADACHE CENTER.

NAME

ADDRESS

STATE

ZIP CODE PHONE

MAIL TO: RICHMOND HEADACHE CENTER
909 Hioaks Road, Suite I
Richmond, Virginia 23225

RICHMOND HEADACHE CENTER

909 Hioaks Road, Suite I
Richmond, Virginia 23225
Telephone (804) 320-3750

VIRGINIA
MEDICAL
APRIL 1990

House Dust Mites in Williamsburg, Virginia

Mark T. Lassiter, MA, and Norman J. Fashing, PhD,
Williamsburg, Virginia

House dust allergy is a common medical ailment. It has been well established that mites of the genus *Dermatophagoides* (house dust mites) are an important source of allergens and that mite counts greater than 300 per gram of dust are associated with symptoms of asthma. A survey of 22 houses in Williamsburg, Virginia, during the month of August revealed that all had mite populations exceeding this number. This may explain in part the high incidence of allergy in the Williamsburg area.

ALLERGIC REACTIONS to house dust in the form of perennial rhinitis, asthma, atopic dermatitis, and possibly urticaria are a common medical ailment throughout much of the world.[1] Mites, especially *Dermatophagoides farinae* and *D pteronyssinus*, play a major role in the production of dust allergens.[1,2] If mite-associated dust allergens are to be eliminated from houses and work places, it is important to know the species composition, densities and locations of mite populations. Surveys conducted in numerous locales worldwide have revealed that such parameters vary widely with geographic location and climatic factors, making it evident that such surveys must be undertaken on a "by-locality" basis.

The present study investigated mite populations inhabiting house dust in Williamsburg, Virginia, an area with an extremely high incidence of allergy (Dr. Scott Pharr Jr., MD, otolaryngologist, personal communication). Objectives were 1) to determine the species of mites represented as well as their densities, 2) to determine whether population numbers differ in beds, sofas and rugs, and 3) to attempt to find associations between population densities and cleaning habits as well as other environmental conditions within houses.

From the Department of Biology, College of William and Mary, Williamsburg VA 23185. Address correspondence to Professor Fashing.

When this work was done, Mr. Lassiter was a graduate student at William and Mary. He is now in the Department of Entomology at North Carolina State University, Raleigh.

Submitted 7-26-89.

Materials and Methods

Dust samples were collected from 22 middle-income, single-family dwellings in the Williamsburg area in 1982. Dust mite populations vary with the seasons and peak during late summer, typically August.[2-7] All samples were therefore collected in August to provide maximal population estimates.

Samples were collected from four sites within each home: bed mattress, bed pillow, carpet beside bed, and sofa (usually in a different room). The collection apparatus consisted of a plastic vial 1¼ inches in diameter and 4 inches in length. A dispenser nozzle was inserted on one end of the vial to concentrate the vacuum, and a 44-μm mesh screen was attached to the other to trap dust and mites. The mesh end of the vial was connected to the hose of a General Electric model PIC-200 vac-

uum cleaner. At each collection site, the nozzle (6.4-mm diameter opening) was passed over the substrate for one minute, vacuuming an approximately 116 cm^2 collection area as follows: 1) mattress—184 cm of the top seam including a corner at both the head and foot; 2) pillow—184 cm around the seam; 3) carpet—92 cm straight line beside the bed (the 92 cm distance was used to approximate the increased surface area of collecting both from the side of piling and the pile mat); 4) sofa—184 cm around the cushion seams. Each vial was weighed before and after the collection to determine the sample weight.

Shortly after collection, each sample was flushed from the collection vial into a 44-μm mesh sieve, using distilled water. The sieve containing the sample was stored in a sealed jar with a thin layer of 85% ethyl alcohol and analyzed at a later date.

For analysis, the sieve was removed from the storage jar and flushed with distilled water to remove the sample into a petri dish. Alcohol remaining in the jar was poured through the sieve and the sieve then checked for any remaining mites under a dissecting microscope. These mites were added to the sample. The petri dish containing the dust sample was then placed on a black surfaced grid and examined under a dissecting microscope. Small probes were used to break up consolidated debris and clusters of mites. All non-pyroglyphid species were separated out and mounted on slides for identification under a phase contrast microscope. The total number of pyroglyphid mites was then counted. To determine the number of each species of *Dermatophagoides* present in a given sample, a species ratio was utilized. To establish the ratio, a random sample of 50 adults was separated out, slide mounted and identified under a phase contrast microscope. If there were less than 50 adults in the sample, all were examined.

A questionnaire designed to obtain information concerning environmental conditions within each house was completed by the person responsible for home cleaning immediately following the collection of samples. Data collected concerned the age of the house, mattress and sofa; type of heating and colling; type of carpet; type of bed covering; frequency of usage of bed and sofa; cleaning frequency for mattress, mattress cover, sheets, sofa and carpet; and presence of pets.

Fig. 1. Male house dust mite. Bar = 200 micrometers.

Results

Mites Represented. Although a given sampling site within a house was sometimes devoid of mites, mites were found in each of the 22 houses sampled. Table 1 provides a breakdown of the 9,387 total mites found in the dust samples. Four suborders were represented—Astigmata, Oribatei, Prostigmata and Mesostigmata. Members of the genus *Dermatophagoides* accounted for 98% of all mites collected. *Dermatophagoides farinae* was present in all houses and made up 70% of the mites collected, whereas *D pteronyssinus* occurred in 21 of the 22 houses and made up 28%. Other astigmatid mites, primarily *Tyrophagus*, were present in nine houses but only in small numbers. Prostigmatid mites accounted for 1% of the total and were found in 16 houses. All but one were in the family Cheyletidae. Mesostigmatid mites were found in ten houses for a total count of 22 individuals. Oribatid mites were found in only five

Table 1. Mites Collected From House Dust in Williamsburg, Virginia.

Taxa Represented	Number of Mites Represented		Number of Houses	
	Total	Percent	Total	Percent
Astigmata	9219	98.21	22	100.00
Acaridae	23	0.24	9	40.91
Tyrophagus sp	22	0.23	9	40.91
Unidentified sp	1	0.01	1	4.55
Pyroglyphidae	9196	97.96	22	100.00
Dermatophagoides farinae	6547	69.74	22	100.00
Dermatophagoides pteronyssinus	2649	28.22	21	95.45
Oribatei	46	0.49	5	22.73
Prostigmata	100	1.06	16	72.72
Cheyletidae	99	1.05	16	72.72
Acaropsis sp	12	0.13	2	9.09
Cheyletus sp	20	0.21	5	22.73
Unidentified sp	67	0.71	14	63.64
Mesostigmata	22	0.23	10	45.45
Digamasellidae	1	0.01	1	4.55
Digamasellus sp	1	0.01	1	4.55
Dermanyssidae	1	0.01	1	4.55
Dermanyssus gallinae	1	0.01	1	4.55
Laelapidae	1	0.01	1	4.55
Hypoaspis sp	1	0.01	1	4.55

homes—one bed sample contained 40, whereas only six individuals were found in the other four houses combined.

Both *D farinae* and *D pteronyssinus* were found in 95% of the houses, with *D farinae* dominant in 16 (76%) and *D pteronyssinus* dominant in only five (24%) (Fig. 2).

Habitat Comparisons. Mites were found to inhabit mattresses and carpets in all 22 houses sampled, sofas in 21 houses, and pillows in 20 houses. The largest population occurred in the sofa in 50% of the houses, whereas in 45% of the houses the largest population was found in the mattress. In only one house was the largest population found in the carpet.

Mite densities in the different collection sites were compared in two ways: 1) actual number of mites observed and 2) the number of mites present per gram of dust (Table 2). Both sets of data—mite number per sample and mite number per gram of dust—were subjected to a oneway analysis of variance (ANOVA) followed by a Student-Newmann-Keuls test. Since data were in the form of counts, a square root transformation was used to provide a better fit to the ANOVA model.[8] In both analyses, mite populations in sofas were not significantly different in number from those in mattresses; however, mite densities in carpets and pillows were found to be significantly different from each other as well as from those in both the mattresses and sofas.

Effects of Environmental Conditions. No significant correlation was found between mite density and years in residence, house age, mattress age or sofa age. Oneway ANOVAs were used to test whether mite densities were affected by environmental conditions. There was no significant difference in mite densities per gram of dust in regard to type of heat, bed age (≤10 yrs vs >10 yrs), bed use (≤8 hrs/day vs >8 hrs/day), sheet change (1/wk vs <1/wk), mattress cleaning (yes vs no), carpet type (tight pile vs shag), carpet cleaning (≥1/wk vs <1/wk), sofa age (≤5 yrs vs >5 yrs), sofa cleaning (yes vs no), and presence of pets (yes vs no). A significant difference was found, however, in regard to sofa use. Those used less than five hours per day had significantly lower mite densities than those used five hours or more per day ($p = .01$). Since almost all homes were air conditioned and since most mattress coverings were cleaned, these variables were not analyzed.

Discussion

It has been well established that the most common mite species found in house dust are members of the family Pyroglyphidae, and the present study supports this fact (Table 1). Non-pyroglyphid species are generally accidentals in the house dust system. An exception to this are some species of the family Cheyletidae, which prey on *Dermatophagoides* and are therefore an important component of the house dust community.[9,10]

We found only two representatives of the Pyroglyphidae, *D farinae* and *D pteronyssinus*, in Williamsburg dust samples. Other species, expecially *Euroglyphus maynei*, have been recorded from homes in the U.S., although usually in small numbers.[10-13] It is possible that other species were present in some of our

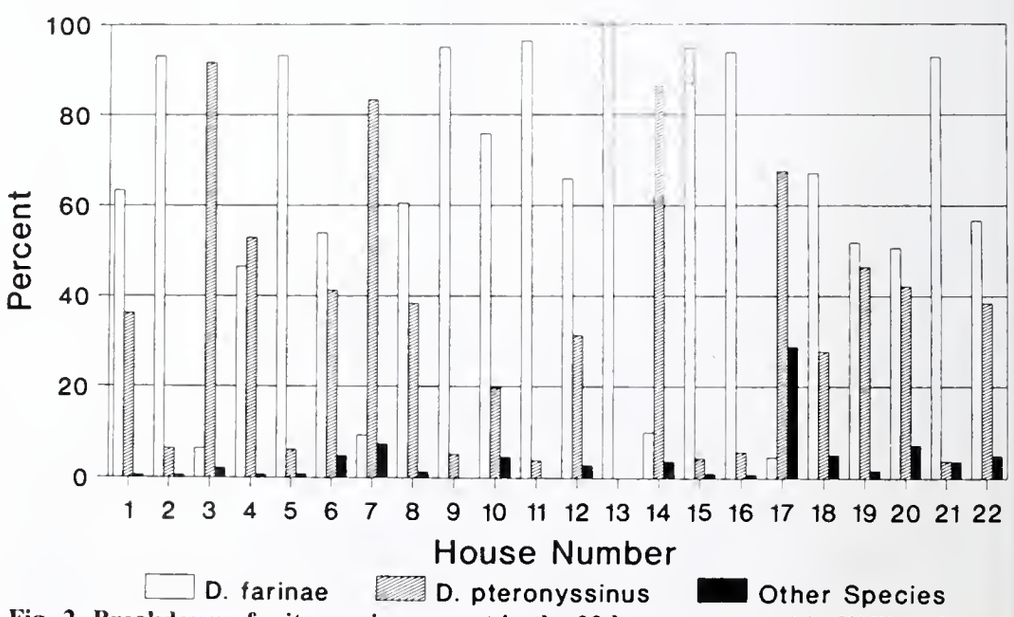


Fig. 2. Breakdown of mite species present in the 22 houses surveyed in Williamsburg.

samples, but due to their small numbers, not selected in the subsamples taken to determine pyroglyphid composition. However, in other studies concerning house dust mites in Virginia, *D farinae* and *D pteronyssinus* were also the only pyroglyphids identified.[14,15]

Although *D pteronyssinus* was found to be dominant in coastal California,[11] Atlanta, Georgia,[13] and Vancouver, British Columbia,[16] in most areas of North America *D farinae* has been found to be the most abundant house dust mite and *D pteronyssinus* the second most abundant.[4,10,12,17,18] This pattern of abundance was also found in our study, with *D farinae* constituting 70% of all mites sampled and *D pteronyssinus* 28% (2.5:1 ratio). In studies conducted around Charlottesville, Virginia, 120 miles west of Williamsburg, Platts-Mills et al[14] also found members of the genus *Dermatophagoides* to be the most common mite species (95.6%); however, they found *D pteronyssinus* and *D farinae* to occur in approximately equal numbers. In the Hampton Roads area, 50 miles east of Williamsburg, King et al[15] found *D farinae* to be dominant on home ported US Navy vessels (5.8:1 ratio) and *D pteronyssinus* to be dominant in houses (2.9:1 ratio). The reasons for such locality differences remain unknown, although the climate in each of the areas is different.

There is a high incidence of coexistence of *D farinae* and *D pteronyssinus* in the Williamsburg area (21 of 22 houses sampled). A high rate was also recorded for Atlanta, Georgia (17 of 20 houses sampled),[13] but such is not always the case. In two reports concerning houses from both Dayton and Cincinnati, Ohio, Arlian et al[2,4] described only seven of 19 (33%) and eight of 18 (44%) houses, respectively, containing both species. In houses inhabited by both species, dominance also varies with locality. We found *D farinae* to be dominant in 16 houses (76%), a percentage very similar to those reported from Ohio (86% and 75%).[2,4] Smith et al,[13] however, found *D farinae* to be dominant over *D pteronyssinus* in only 41% of the houses in Atlanta. They found *D pteronyssinus* dominant in 47% of the houses and the two species to be about equal in number in 12%.

Table 2. Summary of Mite Densities in Collection Sites in 22 Homes in Williamsburg.

Collection Site	Mean	Standard Error	Range
		Total Mites Collected per Sample	
Mattress	132	2.63	7–988
Pillow	6	0.09	0–40
Carpet	59	0.87	5–341
Sofa	125	1.49	0–613
		Mites Collected per Gram of Dust	
Mattress	4099	52.23	250–14500
Pillow	471	9.96	0–4000
Carpet	1483	30.91	73–9700
Sofa	4580	38.45	0–14700

Some sites within a house have more optimal microenvironmental conditions for mite population growth than others, with padded furnishings usually supporting the highest populations.[19] In this regard, the sofa has been found by some investigators to have large mite populations,[3,6,19] and our study supports this finding. During use, temperature and humidity rises, and the padding allows these conditions to be maintained for a period after use. Additionally, when there is sufficient use, the sofa will collect skin dander and other dust elements.

Another padded furnishing, the bed, has also been shown to harbor large mite populations.[6,19,21,22] It provides an excellent microclimate for development of mite populations and can sustain them throughout the year, though density fluctuations do occur.[2] Skin dander accumulates in beds and extended use elevates the temperature and humidity. Coverings on the bed also assist in retaining the humidity and moderating temperature changes. The bed has been implicated as a breeding site[22,23] and can be a reservoir from which mites spill over into other areas of the house during seasons of peak densities.[6] The mattress, mattress cover, pillow and bed covering all contribute to the bed's microclimate; however, the mattress appears to be the major infestation site and contains the highest populations.[6,12,19–23] The pillow, on the other hand, is found to have the fewest mites.[12,22] Our study reinforces these findings—pillows yielded little dust and few mites, whereas mattresses yielded large numbers of mites.

Not all studies have implicated mattresses as a primary source of mites. Arlian et al[2,4] report that carpets and sofas are the principal source of mites in Ohio. The accumulation of dust in carpets supports mite populations well when humidity and temperature are suitable. The most important carpet sites for high mite densities occur in the bedroom and the family room.[3,6] Our study dealt only with dust samples from carpets beside beds and the mite density levels were of intermediate number in comparison to the other sites investigated.

Any environmental condition affecting humidity, temperature or dust accumulation within the mites' microhabitat should have an impact on mite density. Therefore variables such as type of construction, heating, cooling, ventilation, personal cleaning habits, etc., should be important.[19,23,24] However, since each home has its own unique combination of physical factors which affect its microhabitats and their microclimates, it is extremely difficult to collect data which statistically demonstrate that such variables have an influence on mite density. Arlian et al[2,4] found no correlation between mite density and mattress age, mattress use, sofa age, sofa use, bedroom and family room carpet age, sheet change frequency, mattress pad cleaning, house age or

years in residence. Nor did they find mite abundance affected by the frequency of cleaning or the presence or absence of humidifiers. The only significant difference they found related to type of floor covering, with long pile carpets such as shag having larger mite populations than short pile carpets or floors without carpets. The present study also found little effect of physical factors on mite populations; however, contrary to the above study, we did find that sofa use influenced mite populations, but found no effect due to carpet type. It is apparent that a study utilizing larger sample sizes and exercising much greater control over the variables will be necessary to determine which physical factors are important in regulating mite densities.

If is of interest to compare mite densities found in homes in Williamsburg with those found at other localities. Table 3 provides the results of a literature survey which gleaned the highest mean values for mite densities in houses on a worldwide basis. Densities in Williamsburg are quite high compared with other areas of the USA as well as most other areas of the world. The importance of relative humidity on the growth of mite populations has been well established.[1,2] High humidity throughout the year combined with mild winters are undoubtedly contributing factors to the high mite populations found in Williamsburg houses. Mite counts greater than 300 per gram of dust have been associated with symptoms of asthma.[14] All Williamsburg homes surveyed had populations in excess of this number, and this explains in part the reason for the high incidence of allergy.

Table 3. Comparison of House Dust Mite Population Densities (mean number of mites per gram of dust) from the U.S.A. and Other Parts of the World.

Location	Mean Number Mites/Gram	Time of Year	Site
Paupa New Guinea[25]	1378*	—	Beds
Japan & Taiwan[26]	1054	—	Mixed
Iran[24]	3293*	Sept	Mixed
Algeria[27]	>7000	April	Mattresses
India, Lucknow[28]	1986*	—	Unencased Mattresses
Israel, Bat Yam[29]	2473	Dec-Aug	Sofas
Switzerland, Basel[21]	6000–8000	Over year	Mattresses
The Netherlands[30]	575**	July	Floors
Belgium, Haverlee[31]	4597	Feb	Mattresses
France (lowlands)[32]	2120	Sept	Mattresses
Finland[33]	1506*	—	Mattresses
Denmark[34]	4080***	Aug	Beds
United Kingdom			
Scotland, Glasgow[22]	1539	—	Beds
Scotland, Orkney (farms)[35]	1215	—	Mattresses
England, Birmingham[20]	4241*	Aug-Sept	Mattresses
England, London[36]	2568	Over year	Mattresses
Barbados[37]	4440*	—	Mattresses
United States			
Colorado, Denver[38]	240*	Sept	Imported Mattresses
Ohio, Columbus[12]	382*	Summer	Mattresses
Ohio, Dayton/Cincinnatti[2]	1110**	June	Mixed
Tennessee, Knoxville[39]	343*	—	Mixed
Georgia, Atlanta[13]	100	Over year	Beds
Virginia, Charlottsville[40]	897*	—	Mixed
Virginia, Charlottsville[7]	2000**	Aug	Beds
Virginia, Williamsburg	4580	Aug	Sofas
	4409	Aug	Mattresses
	1483	Aug	Carpets

* estimated from table; ** estimated from graph; *** median

This research was supported in part by a faculty summer research grant and a faculty research leave grant awarded to NJF by the College of William and Mary. Special appreciation goes to Dr. Gisela Fashing, Virginia Department of Public Health, for critically reading the manuscript.

References

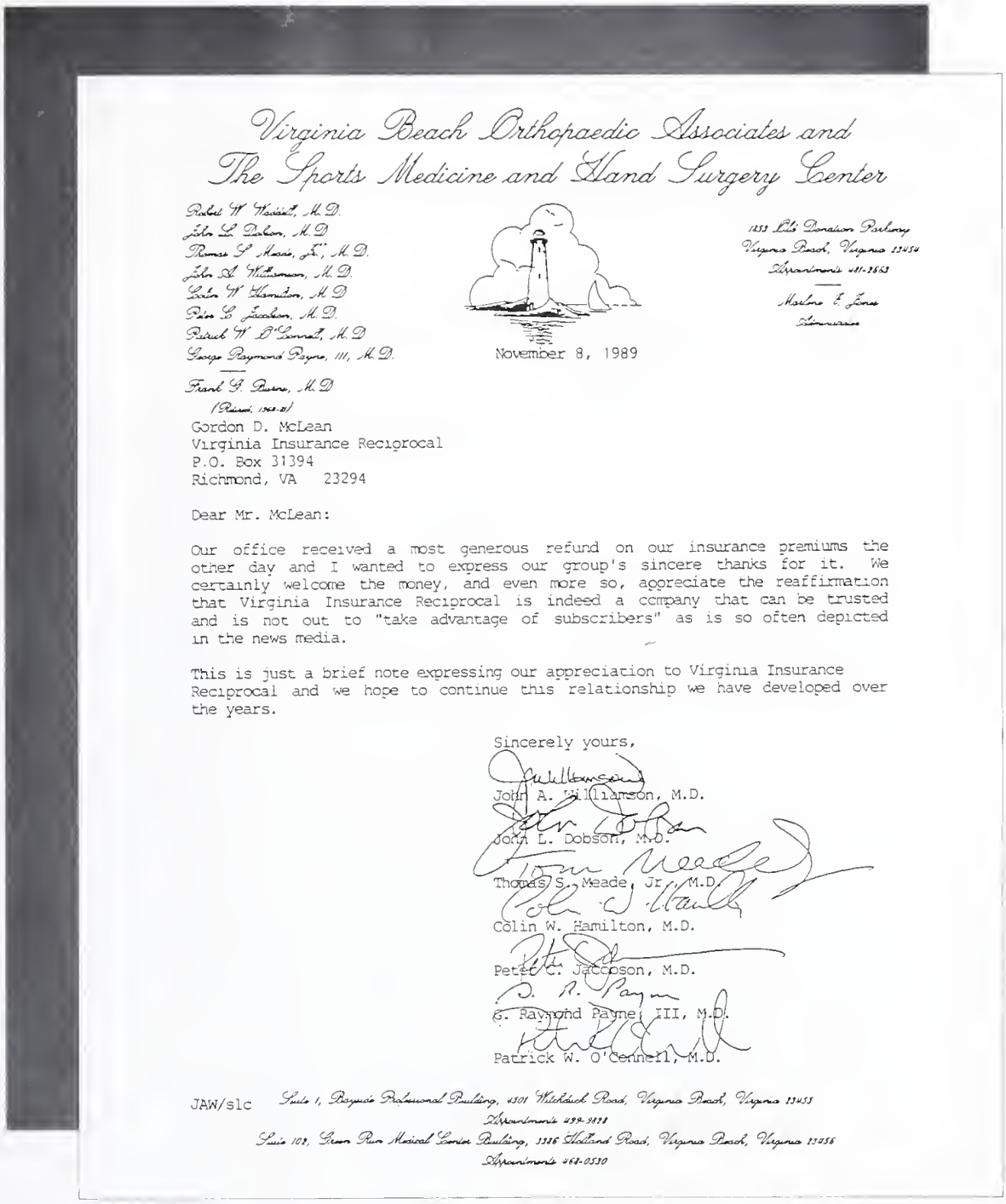
1. Platts-Mills TAE, Chapman MD. Dust mites: Immunology, allergic disease, and environmental control. J Allergy Clin Immunol 1987;80:755-775
2. Arlian LG, Bernstein IL, Gallagher JS. The prevalence of house dust mites, *Dermatophagoides* spp, and associated environmental conditions in homes in Ohio. J Allergy Clin Immunol 1982;69:527-532
3. Woodford PJ, Arlian LG, Bernstein IL, Johnson CL, Gallagher JS. Population dynamics of *Dermatophagoides* spp in southwest Ohio homes. *In* Rodriquez JR (ed). Recent Advances in Acarology 1979; Vol II, 197-204
4. Arlian LG, Bernstein IL, Johnson CL, Gallagher JS. Ecology of house dust mites and dust allergy. *In* Rodriquez JG (ed). Recent Advances in Acarology 1979; Vol II, 185-195
5. Dusbabek F. Dynamics and structure of mixed populations of *Dermatophagoides farinae* and *D pteronyssinus*. *In* Rodriguez JG (ed). Recent Advances in Acarology 1979; Vol II, 173-177
6. Bronswijk JEMHv. *Dermatophagoides pteronyssinus* (Trouessart, 1987) in mattress and floor dust in a temperate climate (Acari: Pyroglyphidae). J Med Entomol 1973;10: 63-70
7. Platts-Mills TAE, Hayden ML, Chapman MD, Wilkins S. Seasonal variation in dust mite and grass-pollen allergens in dust from the houses of patients with asthma. J Allergy Clin Immunol 1987;79:781-791
8. Sokal RR, Rohlf FJ. Biometry. WH Freeman & Company, 1981, San Francisco, 859 pp
9. Bronswijk JEMHv. House-dust as an ecosystem. *In* Rodriguez JG (ed). Recent Advances in Acarology 1979; Vol II, 167-172
10. Bronswijk JEMHv, Sinha RN. Pyroglyphid mites (Acari) and house dust ecology. J Allergy 1971;47:31-52
11. Furumizo RT. Geographical distribution of house-dust mites (Acarina: Pyroglyphidae) in California. Calif Vector News 1975;22:89-95
12. Yoshikawa M, Bennett PH. House dust mites in Columbus, Ohio. Ohio J Sci 1979;79:280-282
13. Smith TF, Kelly LB, Heymann PW, Wilkins SR, Platts-Mills TAE. Natural exposure and serum antibodies to house dust mites of mite-allergic

children with asthma in Atlanta. J Allergy Clin Immunol 1985;76:782-788
14. Platts-Mills TAE, Heymann PW, Chapman MD, Hayden ML, Wilkins SR. Cross-reacting and species-specific determinants on a major allergen from *Dermatophagoides pteronyssinus* and *D farinae*: Development of a radioimmunoassay for antigen P_1 equivalent in house dust and dust mite extracts. J Allergy Clin Immunol 1986;78:398-407
15. King MJ, Betts LS, Sonenshine DE. House dust mites in naval ships, military barracks, and homes in the Hampton roads area of Virginia. Military Medicine 1989;154:30–36
16. Murry AB, Zuk P. The seasonal variation in a population of house dust mites in a North Ameriean city. J Allergy Clin Immunol 1979;64:266-269
17. Sinha RN, Bronswijk JEMHv, Wallace HAH. House dust allergy, mites and their fungal associates. Can Med Assoc J 1970;103:300-301
18. Wharton GW. Mites and commereial extracts of house dust. Scienee 1970; 167:1382-1383
19. Bronswijk JEMHv. House Dust Biology. NIB Publishers 1981, the Netherlands, 316 pp
20. Blythe ME, Williams JD, Smith JM. Distribution of pyroglyphid mites in Birmingham with particular reference to *Euroglyphus maynei*. Clin Allergy 1974;4:25-33
21. Mumcuoglu Y. House dust mites in Switzerland. J Med Entomol 1976; 13:361-373
22. Sesay HR, Dobson RM. Studies on the mite fauna of house dust in Scotland with special reference to that of bedding. Acarologia 1972;14:384-392
23. Wharton GW. House dust mites. J Med Entomol 1976;12:577-621
24. Amoli K, Cunnington AM. House dust mites in Iran. Clin Allergy 1977; 7:93-101
25. Anderson HR, Cunnington AM. House dust mites in the highlands of Papua New Guinea. Papua New Guinea Med J 1974;17:304-308
26. Oshima S. Studies on the mite fauna of the house dust of Japan and Taiwan with special reference to house dust allergy. Jpn J Sanit Zool 1970; 21:1-17
27. Abed-Benamara M, Fain A, Abed L. Note preliminairc sur la fauna acarologique des poussieres de matelas d'Alger. Acarologia 1983;24:77-83
28. Maurya KR, Jamil Z. Faetors affecting the distribution of house-dust mites under domestie eonditions in Lucknow. Indian J Med Res 1980; 72:284-292
29. Feldman-Muhsam B, Mumcuoglu Y, Osterovieh T. A survey of house duse mites (Acari: Pyroglyphidae and Cheyletidae) in Israel. J Med Entomol 1985;22:663-669
30. Bronswijk JEMHv, Sehoonen JMCP, Berlie MAF, Lukoschus FS. On the abundance of *Dermatophagoides pteronyssinus* (Trouessart, 1987) (Pyroglyphidae: Acarina) in house dust. Res Popul Ecol 1971;13: 67-79
31. Gridelte-de-Saint-Georges D. Techniques d'extraction applicables a l'-etude eeologique des acariens des poussieres de maison. Comparaison qualitative et quantitative de divers types de poussieres. Aearologia 1976;17:691-708
32. Vervloet D, Penaud A, Razzouk H, Senft M, Arnaud A, Boutin C, Charpin J. Altitude and house dust mites. J Allergy Clin Immunol 1982; 69:290-296
33. Stenius B, Cunnington AM. House dust mites and respiratory allergy: A quantitative survey of species occuring in Finnish house dust. Scand J Respir Dis 1972;53:338-348
34. Mosbech H, Korsgaard J, Lind P. Control of house dust mites by electrical heating blankets. J Allergy Clin Immunol 1988;81:706-710
35. Jeffrey IG. The mite fauna associated with "barn allergy" on three Orkney farms. *In* Griffiths DA, Bowman CE (eds). Acarology VI 1984; Vol. II, 1154-1160
36. Maunsell K, Wraith DG, Cunnington AM. Mites and house-dust allergy in bronchial asthma. Laneet 1968;1267-1270
37. Pearson RS, Cunnington AM. The importanee of mites in house dust sensitivity in Barbadian asthmatics. Clin Allergy 1973;3:299-306
38. Moyer DB, Nelson HS, Arlian LG. House dust mites in Colorado. Ann Allergy 1985;55:680-682
39. Shamiyeh NB, Bennett SE, Hornsby RP, Woodiel NL. Isolation of mites from house dust. J Eeon Entomol 1971;64:53-55
40. Chapman MD, Heymann PW, Wilkins SR, Brown MJ, Platts-Mills TAE. Monoclonal immunoassays for major dust mite (*Dermatophagoides*) allergens, *Der p* 1 and *Der f* 1, and quantitative analysis of the allergen content of mite and house dust extracts. J Allergy Clin Immunol 1987;80:184-194

Help for a troubled friend is only a phone call away.

If you suspect a colleague is experiencing problems with alcohol or drug abuse, don't contribute to the "conspiracy of silence," call The Medical Society of Virginia's Physicians' Health and Effectiveness Committee. A non-punitive approach through rehabilitation *is* an alternative. Your report will be kept confidential. Ask for Jeanne Douglas at MSV headquarters, (804) 353-2721.

Don't take our word for it...



Virginia Beach Orthopaedic Associates and
The Sports Medicine and Hand Surgery Center

Robert W. Waddell, M.D.
John L. Dobson, M.D.
Thomas S. Meade, Jr., M.D.
John A. Williamson, M.D.
Colin W. Hamilton, M.D.
Peter C. Jacobson, M.D.
Patrick W. O'Connell, M.D.
George Raymond Payne, III, M.D.

Frank G. Burns, M.D.
(Retired, 1968-81)

1253 Old Donation Parkway
Virginia Beach, Virginia 23454
Appointments 481-2663

Marlene E. Jones
Administrator

November 8, 1989

Gordon D. McLean
Virginia Insurance Reciprocal
P.O. Box 31394
Richmond, VA 23294

Dear Mr. McLean:

Our office received a most generous refund on our insurance premiums the other day and I wanted to express our group's sincere thanks for it. We certainly welcome the money, and even more so, appreciate the reaffirmation that Virginia Insurance Reciprocal is indeed a company that can be trusted and is not out to "take advantage of subscribers" as is so often depicted in the news media.

This is just a brief note expressing our appreciation to Virginia Insurance Reciprocal and we hope to continue this relationship we have developed over the years.

Sincerely yours,

John A. Williamson, M.D.

John L. Dobson, M.D.

Thomas S. Meade, Jr., M.D.

Colin W. Hamilton, M.D.

Peter C. Jacobson, M.D.

G. Raymond Payne, III, M.D.

Patrick W. O'Connell, M.D.

JAW/slc

Suite 1, Bayside Professional Building, 4501 Witchduck Road, Virginia Beach, Virginia 23455
Appointments 499-9828
Suite 102, Green Run Medical Center Building, 3386 Holland Road, Virginia Beach, Virginia 23456
Appointments 468-0530

[Unsolicited testimonial from one of the many thousands of physicians' groups which received an equity return distribution during 1989.]

Call us . . . we reciprocate.

The Virginia Insurance Reciprocal

4200 Innslake Drive
Glen Allen, Virginia 23060
Toll free: 1 800 284-TVIR—In Richmond: 747-8600

Ehrlichiosis in Virginia: Case Reports

Milton Ende, MD, P. M. O'Donnal, MD,
F. I. Ende, MD, and Mark Ende, MD,
Petersburg, Virginia

HUMAN ehrlichiosis caused by an *Ehrlichia canis*-like organism was first described in this country in 1987.[1] Since that time scattered case reports have appeared in the literature, from different states.[2,3,4] This report deals with two cases in Virginia; one of these two patients *may* have had Lyme's disease at the same time.

Case Reports

The first patient was a 66-year-old male farmer who was admitted to the Southside Regional Medical Center, Petersburg, on 18 May 1989 with a history of being in excellent health until about one week prior to hospitalization. He complained of being weak, cold, hot, sweating and tremulous. There was no nausea, vomiting or diarrhea. He had noted tremor of his hands about four days prior to hospitalization. He had removed ticks on several occasions during the previous two weeks. On examination he was a well-nourished male who appeared toxic and had a resting tremor. A fine macular rash was noted throughout the trunk, extending even to the scalp. The patient was thought to have Rocky Mountain spotted fever or Lyme's disease and was started on tetracycline and ceftriaxone (Rocephin®). Lumbar puncture was normal, EEG negative, BUN 41, WBC 3,900 with 51% lymphs, platelet count 79,000. Liver function tests on admission were abnormal, AP 123, GGT 72, SGPT 83. Temperature was 102° and became normal in 24 hours. Rash and tremor improved. Agglutination for Rocky Mountain spotted fever was positive 1:256, IGM negative. The test for Lyme's disease was negative. He was discharged on tetracycline. It was felt he should be tested for *Ehrlichia canis* and the results were markedly positive, being 1:4096, IGM was positive >1:20, the latter indicative of a recent infection. Since leaving the hospital the patient has been followed in the office, and two months after the hospitalization complains of feeling weak and aching across the chest and shoulders. Followup test for *Ehrlichia canis* was IGG 1:1024, IGM <1:20.

Table 1. Test Results in Patient One

Date	Test	Results
	Lyme Disease	
5/18/89	ABS Quan EIA	Negative
	Ehrlichia canis	
5/20/89	IGG	1:4096
	IGM	>1:20*
9/21/89	IGG	1:1024
	IGM	<1:20

*IGM greater than 1:20 means recent infection

The second patient was a 69-year-old male transferred to Southside Regional Medical Center on 30 June 1989 from another hospital. Approximately one week prior to hospitalization the patient became ill, with chills, malaise, fever, nausea and nervousness. His wife stated she had taken ticks off of his back. His past history was significant for a bleeding ulcer and hypertension, and he had been found to have abnormal liver studies prior to his transfer. On physical examination patient's temperature was 102°. General physical exam was negative. Neurological survey done in its entirety was negative. The initial impression was the patient had Rocky Mountain spotted fever, Lyme's disease or ehrlichiosis. Patient was started on Rocephin, one gram daily, and tetracycline. His temperature came down to normal in 48 hours. Studies revealed the blood cultures to be negative, hemoglobin 14.6, WBC 5,200, LDH 568, GGT 56, GOT 86, glucose 232, BUN 38, creatinine 2.6. He had heavy proteinuria. In addition, this patient was found to have a positive anti-HBS and positive HBC, indicating previous hepatitis B infection, but it was felt that this played no part in the present illness. The 24-hour urine collection showed creatinine clearance of 39 cc and 6,300 mg of protein. BUN rose to 54 and creatinine to 3.3, indicating a nephrotic syndrome. Patient showed prompt improvement on the above medications and became greatly desirous of leaving the hospital before results of the studies for various tick diseases were received.

Table 2 shows a rise in titer for ehrlichiosis, confirming the diagnosis of this disease. Also, the titer for Lyme's disease rose from zero to 2.77 index suggesting this patient may also have had this disease.

The patient was readmitted on 15 August 1989 because of severe abdominal pain and discomfort in his legs and arms. Physical examination at this time revealed his abdomen to be tender but there was no rebound. During the course of his hospital stay the pain in the patient's arms and legs became extremely intense. He felt numbness in his feet. His knee jerks were absent. CT scan of the lumbar spine showed spinal stenosis due to a combination of short pedicles

Dr. Milton Ende and his sons practice internal medicine together at 121 South Market Street, Petersburg, VA 23803. Dr. O'Donnal practices neurology in Petersburg.

This paper was supported by the Abraham S. Ende Research Foundation.

Submitted 12-4-89.

Table 2. Test Results in Patient Two

Date	Test	Results
	Lyme Disease	
6/30/89	ABS Quan EIA	Negative
	ABS IGM Quan EIA	<1.0
7/6/89	ABS Quan EIA	2.77*
	ABS IGM Quan EIA	<1.0
8/15/89	ABS Quan EIA	2.41
	ABS IGM Quan EIA	<1.0
8/24/89	ABS Quan EIA	2.23
	ABS IGM Quan EIA	<1.0
9/15/89	Lyme total antibody	1.59**
	Ehrlichia canis	
6/30/89	IGG	>or = I:64
	IGM	>or = I:20
7/6/89	IGG	>or = I:64
	IGM	>or = 1:20
8/15/89	IGG	>or = 25
	IGM	weakly positive 1:
8/24/89	IGG	1:512
	IGM	<1:20
9/5/89	IGG	1:512
	IGM	<1:20

Four-fold rise in titer diagnostic of disease

*Index = ratio of patient's titer to general population. Index of 2.77 regarded as mid-positive.

**Positive considered to be 1.00

and hypertrophic changes associated with degenerative arthritis in the facets. Myelogram showed a possible herniation of disc at L_4. Serum amylase was 68. BUN was now 8 mg, sed rate 18, stool for blood was negative, amylase clearance was 4.5%, glucose 162, K 3.3, spinal fluid protein was 155 with no cells. EMG revealed findings suggestive of peripheral neuropathy, bone scan was negative. The patient's abdominal pain appeared to subside on its own, leg and arm pain disappeared.

After this hospitalization the patient was followed in the physician's office. He had exacerbation of severe leg and arm pain and was restarted on tetracycline, which appeared to result in a distinct improvement in limb pain. It was felt that the severe pain was due to peripheral neuropathy as reported in previous cases of ehrlichiosis. His proteinuria improved to 1288 on 18 September 1989. Liver studies returned to normal.

Discussion

Ehrlichiosis is a rickettsial leukocytic infection which was first described in dogs in 1935. This disease is often fatal in animals. The vector of this disease is the brown dog tick, *Rhysicephalus sanguineus*. The organisms are obligate intracellular bacteria which infect mononuclear or polymorphonuclear leukocytes. The leukocytic *Rickettsiae* of the genus *Ehrlichia* include the species *E canis*, *E risticii*, *E equi*, *E phagocytophila*, and *E sennetsu*.[1] Cross-agglutination within the genu exist.

The diagnosis of ehrlichiosis is made by a fourfold rise in titer. Identification of the organism can be made from the infected cells. Electron microscopy shows inclusion bodies in the white cells containing organisms. In both of these cases the patients had left the hospital prior to receiving the report of the elevated serology; therefore, searches for organisms were not done. It is difficult to determine from the literature if cross-reaction titer between *Ehrlichiosis canis* and *Borrelia burdorferi*, the causative agent in Lyme's disease, occurs, although several cases of cross-reactive serology have been reported, as has possible infection with both organisms.[7]

In humans, ehrlichiosis is manifested by fever, myalgia, nausea, chills, headache. Lab changes are leukopenia, thrombocytopenia, abnormal liver studies. Rash occurs in about 20% of the cases. There has been a report of a possible human fatality.[2] The drug of choice in treating rickettsial infection is tetracycline. Next drug would be chloromycetin. The drug ceftriaxone, although quite effective in Lyme's disease, is not effective against rickettsial diseases.[6] Both of the above patients were started on tetracycline along with ceftriaxone. The second patient had moderate increase titer for Lyme's disease. Early treatment can prevent rise in titer in this condition.[5] The increase in spinal fluid protein is more indicative of Lyme's disease than ehrlichiosis.

Summary

Ehrlichiosis is a disease that should be considered in any case of chills, fever and malaise, with or without a history of tick bites.

References

1. Maeda K et al. Human infection with *Erhlichia canis*, a leukocytic richettsia. N Eng J Med 1987;316:853-6.
2. Centers for Disease Control. Human ehrlichiosis, United States. MMWR 1988;37:17-21.
3. Simmons BP, Hughey JR. Ehrlichia in Tennessee. South Med J 1989;82:669.
4. Doran TI, Parmley RT, Logas PC, Chamblin S. Infection with *Elrlichia canis* in a child. J Pediatrics 1989;114:809-12.
5. Dattwyler RJ, Volkman DJ, Luft BJ et al. Seronegative Lyme disease. Dissociation of specifying T- and B-lymphocyte responses to *Borrelia burgdorfe*. N Eng J Med 1988;319(22):1441-6.
6. Eichenfield AH. Lyme disease: of ticks and titers. J Pediatrics 1989;114(2):328-33.
7. Raad I, Singh V, Quan TJ. Concurrent positive serology for ehrlichiosis and Lyme disease. J Infect Dis 1989;160: 727-8.

ABSTRACTS

These abstracts are to be presented at the annual meeting of the Virginia Surgical Society on May 4-6 in Hot Springs. Dr. Irving L. Kron is program chairman.

Arterial Bypass Procedures to the Vessels of the Ankle and Foot. Jesse T. Davidson III, MD, Roanoke.

Twenty-nine arterial reconstructive procedures involving vessels of the ankle or foot have been performed in 27 patients since 1985. Sixteen (59%) of patients were men and 11 (41%) were women. Risk factors included diabetes (78%), cardiac disease (37%), hypertension (33%), tobacco use (30%), and cerebrovascular disease (26%). Indications for operation were gangrene (62%), ischemic ulceration (27%), and rest pain (11%). Autogenous tissue was used for all procedures which included in situ vein (62%), reverse saphenous vein (14%), combination of in situ reversed or translocated vein (16%), lesser saphenous vein (4%), and endarterectomy with vein patch (4%). Distal bypasses were done to the dorsalis pedis artery (62%), posterior tibial artery at the ankle (20%), and distal anterior tibial artery (14%). Proximal anastomoses originated on the common femoral artery (24%), superficial femoral artery (20%), and popliteal artery (48%). There were two postoperative graft failures. One of the failures was revised to femoral-popliteal bypass graft with subsequent limb salvage. Two patients (7%) required below-knee amputations in the postoperative period, one with a patent bypass. Operative mortality was 4%. Cumulative patency at 12 and 24 months was 90%. Autogenous reconstructive vascular procedures at the foot and ankle are effective for limb preservation.

Total Esophagectomy (Blunt) Without Thoracotomy. Juan M. Montero, MD, Chesapeake.

This operation which was first described by W. Denk in 1913 was reintroduced by Dr. George Grey Turner in the 1930s. However, it was not until Dr. Hiroyshi Akiyama took up the operation in the 1960s and Dr. Mark Orringer in the 1970s that interest in the rest of the surgical world was rekindled. The technique features an esophagectomy done without a thoracotomy, using blunt dissection through a combined upper midline abdominal and cervical incisions. Following complete thoracic esophageal resection the stomach is pulled up through the posterior mediastinum and cervical esophagogastric anastomosis is carried out. There is a continuing debate as to the rightful historical place for this relatively "new" operation. Sometimes we are slow to adopt useful new operations, which for this particular one is done for benign and malignant lesions.

For this presentation, I will discuss my experience of five patients with cancer of the esophagus operated on between May 1986 and September 1989.

Colonoscopy in Preoperative Evaluation of Patients with Colorectal Cancer. Luiz E.G. Mineiro, MD, Clifton Forge.

One hundred sixty-seven cases of carcinoma of the rectum and colon were retrieved from a total of 2,412 consecutive colonoscopies performed by the author from 1974 to 1988. These data were checked for synchronous and metachronous lesions. All examinations were done at Alleghany Regional Hospital, a 160-bed rural hospital located in western Virginia. Twenty-five (14.9%) synchronous polyps, 15 (8.9%) metachronous polyps, 5 (2.9%) synchronous carcinomas, and 14 (8.3%) metachronous carcinomas were found. Of the 5 synchronous carcinomas, 4 were not suspected. Three of the operations involving these cases were modified accordingly. Five of the metachronous carcinomas were recurrent tumors. Five of the patients with matachronous tumors did not have a colonoscopy at the time they were first treated because either the original operation was performed elsewhere or preceded the collection of these data.

Based on these findings, it appears that preoperative colonoscopy, in conjunction with the abbreviated bowel preparation discussed in this paper, was helpful in the proper planning of the surgical treatment of our patients and might have prevented development of metachronous cancer.

Percutaneous Cholecystostomy. George C. Hoffman, MD, Norfolk.

Cholecystostomy can be an initial lifesaving procedure for patients with acute cholecystitis who are critically ill and at a very high operative risk. We have performed percutaneous cholecystostomy under local anesthesia in four patients with acute cholecystitis who were considered at excessive operative risk because of multisystem failure. One patient with emphysematous cholecystitis and cholangitis also had obstruction of the distal common duct secondary to a pancreatic neoplasm. All four patients' clinical picture improved following drainage of the gallbladder empyema. One patient died of causes unrelated to the biliary tract. One patient has had a subsequent cholecystectomy and two patients are currently being managed as outpatients with cholecystostomy tubes in

place. A review of the literature addresses indications, the diagnostic value, technical aspects, and subsequent outcomes of patients who have undergone this relatively new and innovative method of gallbladder decompression.

Complications of Dialysis Access—A Six-Year Study. Stephen L. Hill, MD, and Antonio T. Donato, MD, Roanoke.

Chronic renal failure in most patients is permanent, with no hope of transplant, and thus dialysis access problems are chronic and potentially life-threatening complications. We looked at our complications with dialysis access procedures over a six-year period. In this period we had 76 patients and performed 158 procedures. Our first option was always a Cimino fistula. Only 10 patients (13%) were candidates for a Cimino fistula. There were two failures in this group with two other patients requiring revision of an anastomosis two years later. There were no other complications with these fistulae and they continue to function.

The vast majority of the dialysis access procedures were upper arm grafts with reversed tapered PFTE. There were 73 patients in this group and required a total of 147 procedures to keep the grafts patent for the study period or until death. As to be expected, the primary complications were thrombosis and infection. There were no patients with access induced congestive heart failure or symptomatic steal syndrome.

The major complication was thrombosis. There were 24 patients (31%) who required revision, thrombectomy or placement of a new graft over the six-year period. This entailed a total of 57 procedures. In only one patient was a simple thrombectomy done. All other patients required either a major revision with an anastomosis to a new vein or placement of an entirely new graft. The thromboses were almost exclusively caused by obliteration of the venous lumen with pseudointimal hyperplasia. The other major complication was infection. There were 8 patients (10.5%) with an infected graft. This necessitated two procedures: one to remove the graft and repair the artery with an autogenous vein patch, the other to place a new graft in the other extremity. There was a small subset of 5 patients responsible for many of the complications of infection and thrombosis and for over 45% (37) of reoperative procedures in the entire population.

The complications of dialysis are tedious, recurrent, and complex but there are several lessons we have learned. 1) Infected grafts will always have to be removed and require two operative procedures. 2) Thrombosed grafts can only rarely be thrombectomized successfully; more often they will require a major revision of the venous anastomosis or an entirely new graft. 3) A small subset of the dialysis population is not amenable to vascular access due to recurrent thrombosis and/or infection. 4) An autogenous fistula should be placed whenever possible even, if necessary, after a prosthetic graft has already been placed for immediate dialysis.

Use of the Supraclavicular Approach for Surgical Treatment of Thoracic Outlet Syndrome. Stephen W. Ely, MD, Don E. Detmer, MD, Irving L. Kron, MD, and Thomas M. Daniel, MD, Charlottesville.

The present study evaluated the effectiveness of the supraclavicular approach for the surgical treatment of thoracic outlet syndrome (TOS). 21 sequential cases treated at the University of Virginia from July 1986 to December 1989 were retrospectively reviewed. This group included 18 females and 3 males, ages 22 to 44. Through a supraclavicular incision, the following procedures were performed: cervical rib resection (33%), 1st rib resection (68%), anterior scalenectomy (95%), middle scalenectomy (48%), subclavian artery aneurysm repair (5%), and cervical sympathectomy (5%). The mortality rate was 0% and the complication rate was 24%. This included 2 patients with pleural effusions, 1 with pneumothorax, 1 with causalgia, and 1 with a stretch injury of the brachial plexus. There were no vascular complications. All complications were temporary except for the brachial plexus injury which had a 90% recovery at 2 years. Followup was available for 100% at a mean interval of 19.1 months. Excellent relief of symptoms was achieved in 75% initially, but 5 of these 16 patients developed mild to moderate recurrent symptoms in the followup period. 10% showed improvement in their symptoms following surgery and 10% showed no change from their preoperative state. 1 patient (5%) had a worsening of symptoms following surgery and that was the patient with the brachial stretch injury.

This study demonstrates that the supraclavicular approach for TOS allows for the versatility necessary in treating the many possible causations of this syndrome. 85% of the patients were improved by the surgery. The absence of any objective test to diagnose TOS continues to make treatment of this problem a diagnostic and therapeutic challenge.

Clinicopathologic Review of Distal Common Bile Duct Cancers. George A. Parker, MD, Michael Bousamra, MD, and A. Scott Mills, MD, Richmond.

To define the natural history of cancers arising in the distal common bile duct (CBD) a clinical and pathologic review of 22 patients undergoing potentially curative resections was done. Operative mortality was 22%, however there were no operative deaths in the 13 patients treated after 1970. Complications included intraperitoneal abscess in 7 patients, pancreatojejunostomy leak in 3 patients, and enterocutaneous fistulae in 2 patients. Nineteen tumors were either well differentiated (WD) or moderately well differentiated (MWD), 2 were WD or MWD, while 1 was poorly

differentiated. Eight patients had nodal metastases, while 14 did not. The degree of differentiation did not correlate with the presence of nodal metastases. Perineural invasion as well as pancreatic or duodenal invasion occurred in 19 patients. In only 2 instances was the tumor confined to the CBD. Excluding operative deaths the median survival was 22 months. The patients with nodal metastases had a mean survival of 20 months, while those without nodal spread had a mean survival of 33 months. Three years post operation only 3 patients were free of disease: 2 had no invasion of the pancreas or duodenum, and 1 had minimal invasion of the pancreas. We concluded that favorable prognostic factors for resected distal CBD tumors include lack of invasion of surrounding structures and absence of nodal metastases. Degree of differentiation did not correlate with survival or presence of nodal metastasis. Finally, long-term survival was limited to patients with no or minimal involvement of adjacent structures.

Management of Locally Advanced Breast Cancer with Multimodality Therapy. James L. Frank, MD, and Barry D. Bear, MD, Richmond.

Optimal management of locally advanced breast cancer is controversial. Claims of superiority for neoadjuvant systemic therapy are based on comparisons with outdated historical control groups who received no chemotherapy. Between 1978 and 1987, 119 patients with locally advanced breast cancer underwent primary treatment and follow up at the Medical College of Virginia. Clinical substaging included 63 (52%) patients with stage IIIA, 43 (36%) patients with stage IIIB non-inflammatory, and 13 (11%) patients with stage IIIB inflammatory disease. Initial treatment consisted of local therapy in 108 (91%) patients; 11 patients initially received systemic therapy. Fifty-three (49%) patients received conventional systemic adjuvant therapy after local treatment. Median follow up is 44 months (range 3-119 months). Actuarial five year survival for the entire group is 53%. This compares favorably with recent series using neoadjuvant chemotherapy in which 5-year survival rates of 40 to 65% have been reported. Significant prognostic indicators for survival include the percentage of pathologically involved lymph nodes and the presence of an inflammatory component. Steroid receptor status, age, local grave signs, tumor size, and systemic adjuvant therapy did not significantly alter survival. This series represents a contemporary control group of patients with locally advanced breast cancer in whom conventionally accepted guidelines for local and systemic adjuvant therapy were used. Until the optimal sequence of therapy is determined by prospective randomized trials, series such as this may serve as more appropriate controls to which the results of new therapies should be compared.

Gallstone Lithotripsy: Improved Results with Adjuvant Bile Salt Therapy. Bruce D. Schirmer, MD, Daniel J. Pambianco, MD, Janet Dix, PA-C, Sarah Fabian, RN, Patricia Abbitt, MD, Jay Gillenwater, MD, and R. Scott Jones, MD, Charlottesville.

Symptomatic patients with ≤3 non-calcified gallstones and a functioning gallbladder were randomized as part of a prospective double-blind national study to determine the role of adjuvant bile salt therapy in conjunction with extracorporeal shock wave lithotripsy (ESWL) for gallstones. The 31 patients, 22 women and 9 men, average age 50, underwent ESWL treatment using the Dornier MPL 9000 lithotripter. The mean stone volume present prior to treatment was similar for patients receiving ursodeoxycholic acid (URSO, n = 11) and placebo (PLAC, n = 20), at 2.68 ± 2.19 cm^3 and 3.58 ± 3.63 cm^3 respectively. Fourteen patients in the PLAC group and 6 in the URSO group had solitary gallstones. All treatments required only intravenous sedation as anesthesia. Patients received 1500 shock waves at an average of 18 kV. Six weeks post treatment patients with ultrasound-documented fragments ≥5 mm. underwent a second similar ESWL treatment. Nine of 20 PLAC patients and 7 of 11 URSO patients required second treatments. At six months follow-up for all patients 50% (3/6) of URSO patients and 7.1% (1/14) of PLAC patients with initial solitary gallstones were stone and fragment-free ($p < .05$). No patient with multiple stones in either group was stone-free. Patients tolerated the treatments well, but biliary colic, usually mild, was reported following 78.7% of treatments. Only two adverse complications occurred: one patient developed pancreatitis that resolved with conservative care and one patient developed transient jaundice; both patients later had elective cholecystectomy. We conclude that ESWL treatment for gallstones is safe but the efficacy may be less than that reported elsewhere. Adjuvant bile salt therapy appears to improve results in patients with solitary gallstones.

A Single-Center Experience with Pancreas Transplantation: Results and Expectations. Timothy L. Pruett, MD, and John B. Hanks, MD, Charlottesville.

Clinical pancreas transplantation is a therapy which is evolved to relieve Type I diabetics from the need for exogenous insulin, maintain euglycemia and hopefully show the secondary complications of diabetes. Although the early results of clinical pancreas transplants were poor, recent changes in technique and immunosuppression has led to better long-term results. At the University of Virginia, six pancreas allografts have been performed since April 1988, five in combination with kidney transplant and one pancreas allograft alone. All grafts are working, with maintenance of fasting euglycemia and normal hemoglobin A1C levels. Two surgical complications have

occurred, one late rupture of the bladder (six months post transplant) and bleeding from the donor duodenum which has required cystoscopy.

Preliminary evaluation of carbohydrate metabolism in these patients has revealed fasting hyperinsulinemia (in excess of 15μ units/ml with a concomitant blood sugar of 70 to 80 mg/dl) and marked hyperinsulinemia in response to a glucose challenge. There is substantial evidence that carbohydrate metabolism is not normal in spite of the superficial appearance of being "cured" of their diabetes. Metabolic complications have included acidosis and intermittent hyperkalemia presumed secondary to cyclosporine A as well as complicated by the acidosis. Pancreas transplantation is a feasible and reproducable operation to ameliorate the need for exogenous insulin for the Type I diabetic. Its long-term efficacy and benefit for these individuals remains to be discerned. The advent of combined pancreatic and renal transplantation has yielded reproducible results.

Point of View: The Case for Economy Class

As the nation struggles to contain soaring health care expenditures, the decade of the nineties belongs to the nursing profession. Nurses are in short supply, as physicians were during the sixties and seventies. Hospitals compete with higher salaries—for the betterment of health care, in my opinion. Attrition in the nursing profession should decline, as well as the taking of secondary jobs to supplement income.

In the present climate, hospitals cannot function with fewer nurses (though they can get along with fewer physicians). This is evident in some of the hospitals in Hampton Roads, which have closed patient rooms for lack of nurses.

What I can't understand is why hospitals continue to expand the number of private-room beds, knowing the critical nursing situation. What is worse is the total demise of hospital wards. Why is this so, when business sense would seem to dictate that ward beds, which need fewer nurses, are most cost effective? The answer: Wards are looked down on in these times of affluence. "I sure don't want to be known as the administrator of the hospital with wards," quipped one administrator recently.

So there we are. We can no longer afford health care because we have become spoiled by the hospitals' affluence. Everything is first-class—private room with color TV and a telephone. It is time to educate the American public not to equate luxury with quality of care. No health care professional is going to withhold or modify treatment just because the patient is on a ward. And there should be no stigma attached to being on a ward. I always buy an economy-class airplane ticket, and I still arrive at my destination the same time as the guy in the first-class section who was served cocktails as he sat in a wider, more comfortable seat.

Juan M. Montero II, MD
2147 Old Greenbrier Road
Chesapeake, VA 23320

VIRGINIA MEDICAL

The Price of Regulating

THE conflict between the rights of society and the rights and freedom of action of the individual is with us always and is well illustrated in the new requirements discussed in the article on waste disposal in this issue.

Our office has its own waste dumpster, and for years everything was lumped together and dumped therein. We started getting letters from the waste removal company indicating that we should not put sharp objects, specifically plastic syringes with needles, in the dumpster. Finally a letter informed us that it was a federal offense to dispose of needles with the other trash and that we would be fined if we continued to do so. We than bought a supply of the expensive red puncture-resistant containers and arranged to have these incinerated—at an additional price in time and money.

The local hospital spends six to ten times as much to dispose of sharps and waste termed "infectious" as it does for regular waste disposal.

Even though, as indicated in the article, there have been no public health problems associated with the previous methods of disposal of these wastes, we are now shouldered with these rules. We can and will obey the law, but the increased cost will necessarily, as always, be passed on to the public.

RAYMOND S. BROWN, MD

The State Board of Medicine

As the saying goes, "It ain't what it used to be." In this case, reference is made to the State Board of Medicine. When this writer joined the Board in 1976, approximately one-half day of the three-day session was devoted to the impaired physician. Ten years later three-quarters of each entire session dealt with that problem.

During the latter part of that particular ten-year period and culminating in 1985 the State Board of Medicine was the object of multiple criticisms; as stated at that time, the criticisms were:

1) The impaired physician is not recognized; when recognized, he is not reported; when reported, he is not disciplined; and when discipline is accomplished, the process is painfully slow and the physician is often allowed to continue practice for a variably lengthy period of time.

2) The State Board of Medicine is composed of physicians; they are loathe to regulate and discipline their colleagues. There should be public representation on the board.

3) There is no effort to elicit complaints; when complaints are filed, screening of these complaints is accomplished by a single member of the board, and all decisions as to the need for further consideration and/or investigation are made by this member.

Beginning in 1986, all of these criticisms have been answered, some more effectively than others.

Whenever a physician is disciplined by a hospital, this disciplinary measure must be reported to the State Board of Medicine. While the celerity of the process still is the object of some criticism, that, too, has been improved as much as possible. Little can be done about the delay caused by due process of law.

The State Board of Medicine proposed the appointment of one public member. Two were appointed. While there is no real objection to the additional public member, it was hardly the idea of the Board that both appointees would be lawyers. However, these appointments have largely quieted this criticism.

Beginning in 1986, complaints have been solicited, encouraged and facilitated by the provision of a toll-free telephone number. In 1985 there were 258 complaints; by July 1988–89 the number had risen to 371. However, there does appear to be a levelling-off of the curve.

During the period 1967 to 1986 Dr. George Carroll served as secretary of the Board and performed the original screening; in the opinion of most, he did it well. In 1987 the position of medical director of the board was established and Dr. Hilary Connor was appointed to the post. There is no question that a competent full-time director can be more effective than one who serves on a part-time basis and Dr. Connor has acquitted himself well. He, along with the president of the Board, now does the screening. Before a case is permanently closed without a hearing, that case is reviewed by the Board. If the Board does not agree, the case is reopened.

The medical profession in Virginia appears to be well regulated. Now, if certain other professions . . .

E.L.K., Jr.

1. Kendig ELjr. An inside look at the Virginia State Board of Medicine. Va Med 1981;108:439
2. Kendig ELjr. Disciplining doctors: problems and solutions. Richmond Times-Dispatch, 8 Jan 1985
3. Complaints to the State Board of Medicine level off: an interview with G. E. Calvert. Lynchburg Acad of Med *Light* (newsletter) Jan 1990

MEDICAL SOCIETY OF VIRGINIA

President
William H. Barney, MD, Lynchburg
President Elect
John A. Owen, Jr., MD, Charlottesville
Immediate Past President
J. Thomas Hulvey, MD, Abingdon
First Vice President
Leon I. Block, MD, Falls Church
Second Vice President
William W. Regan, MD, Richmond
Third Vice President
William H. Sipe, MD, Newport News
Speaker
George E. Broman, MD, Culpeper
Vice Speaker
Lawrence K. Monahan, MD, Roanoke

Councilors by District
1st: **Louis D. Parham, MD,** Hampton
2nd: **Russell D. Evett, MD,** Norfolk
3rd: **James A. Shield, Jr., MD,** Richmond
4th: **John W. Hollowell, MD,** Portsmouth
5th: **Edwin J. Harvie, Jr., MD,** Danville
6th: **Jeffrey W. Wilson, MD,** Lynchburg
7th: **H. George White, Jr., MD,** Winchester
8th: **Ira J. Green, MD,** Alexandria
9th: **James L. Patterson, Jr., MD,** Pulaski
10th: **Ira D. Godwin, MD,** Fairfax

AMA Delegates
H. C. Alexander III, MD, Roanoke
Raymond S. Brown, MD, Gloucester
Charles M. Caravati, Jr., MD, Richmond
C. Barrie Cook, MD, Falls Chruch
Richard L. Fields, MD, Fairfax
William J. Hagood, Jr., MD, Clover
John A. Martin, MD, Roanoke
Harold L. Williams, MD, Newport News
Percy Wootton, MD, Richmond

Executive Vice President
James L. Moore, Jr.

VIRGINIA MEDICAL OBITUARY

• **Chapman Hunter Binford, MD,** Arlington; Medical College of Virginia, 1929; age 90; died February 9, 1990. Dr. Binford was widely respected for his research in pathology, notably at the Armed Forces Institute of Pathology in Washington.

• **Francis J. Clements, MD,** Yorktown; Medical College of Virginia, 1923; age 93; died January 2, 1990. Originally a general practitioner in Fluvanna County, Dr. Clements worked for the State for 29 years as director of local health departments in Dinwiddie, Mecklenburg, Prince Edward, and Sussex Counties.

• **Robert G. Kindred, MD,** Rockville, Maryland, orthopedic surgeon; University of Virginia School of Medicine, 1948; age 64; died of leukemia in Baltimore on April 27, 1989.

• **Carroll H. Lippard, MD,** Lynchburg obstetrician and gynecologist; University of Pennsylvania School of Medicine, 1946; age 66; died February 13, 1990. He had been president of the Lynchburg Academy of Medicine and the State Board of Medicine.

Memoir of R. B. Grinnan, Jr. 1908-1989

By John Franklin, MD, Samuel McDaniel, MD, Frederick Woodson, MD, and Harry Wise, MD

The son of Presbyterian missionaries whose pastorates extended from Japan to North Carolina, Randolph Bryan Grinnan, Jr., MD, was born in Henderson, North Carolina, but spent the major part of his life in Virginia. He graduated from Maury High School and attended the University of Virginia for his undergraduate and medical school education, receiving his MD degree in 1932. He interned at the Boston City Hospital and served his residency at Doctor's Hospital in New York City. He established his practice in Norfolk thereafter and practiced medicine continuously until his retirement in October 1978.

During his 50 years of practice, Bryan witnessed many changes in the field of medicine, the pattern of diseases, and the causes of death. Respiratory diseases, particularly tuberculosis, were the major killers during the early years of his career, and he positioned himself to play an active role in their prevention and control. He served one summer on the staff of the Loomis Anti-tuberculosis Sanatorium in Liberty, New York, and after arriving in Norfolk became chairman of the Anti-tuberculosis League, participating actively in related clinical research and educational activities. He was a charter member and a fellow of the American College of Chest Physicians and, along with Dr. C. Lydon Harrell, became recognized as a specialist in chest disease.

He witnessed the birth of the therapeutic era of medicine and greeted each new therapeutic modality with enthusiasm, frequently participating in clinical trials. He published papers on his clinical experience with sulfapyridine and sulfathiazole in the treatment of staphylococcal infection and made observations of the potential for these drugs in the prevention of rheumatic heart disease.

The field of cardiac medicine was in its infancy during Bryan's early years. The EKG was invented in 1903 and was not in common use. Myocardial infarction was more frequently recognized after Herrick's description in 1912, and Bryan's interest prompted him to read one of the early papers on coronary occlusion before the Seaboard Medical Association in 1951. He later presented a layman's version of the same paper to the Kiwanis Club in 1957. He became the founding president of the Tidewater Heart Association and played an active role as well at the state and national levels.

Paralytic poliomyelitis was epidemic in the Forties and early Fifties and Bryan, of course, was active in its treatment. In an effort to enlist community support, he became actively involved in the Norfolk City and County Chapters of the National Foundation for Infantile Paralysis.

Few diseases escaped his interest. The management and treatment of diabetes was new, and Bryan played an active role in educating the profession about diabetes and became a member of the American Diabetic Association. In 1950, he presented a paper on "The Pregnant Diabetic" before the Seaboard Medical Society.

Bryan was a life-long member of the AMA and The Medical Society of Virginia. He also strongly supported the Norfolk County Medical Society and served one year as its president. Early in his career he became a diplomate of the American Board of Internal Medicine and, shortly thereafter, attained the status of fellow of the American College of Physicians. He helped organize and became president of the fledgling Virginia Society of Internal Medicine, an organization dedicated to influencing health and social policy. Bryan always had strong views about access to health

care and was as concerned about the distribution of health care as about the health of his community.

He served for many years on the Advisory Commission to the Director of Human Resources in Norfolk and was a member of the Norfolk Hospital Association, where he was able to influence indigent health care. Early on, he strongly advocated a free-standing Public Health Department separate from the Department of Human Resources. When this separation was effected, he served as chairman of the Advisory Commission to the new department. In 1988, he received the first Distinguished Service Award for 40 years of service to the department.

Bryan was always interested in the dissemination of medical knowledge to the profession and to allied health personnel. He frequently participated in the training of nurses, published articles in the VIRGINIA MEDICAL MONTHLY and presented papers to local medical societies. He helped organize a Journal Club for internists and served on the editorial board of a local publication called *The Internist*. He was an active staff member of DePaul and Leigh Memorial Hospitals and served as chief of the Norfolk General Hospital Medical Department. He also served as civilian consultant to the Portsmouth Naval Hospital from 1947 to 1960.

Throughout his life, Bryan loved and enjoyed the outdoors, sharing his extensive knowledge of sailing, hunting and fishing with his three sons. On board his catboat, "The Tempest," they took frequent trips to the Eastern Shore of Virginia and to coastal North Carolina. In his later years, sensitive to the diminishing quality of our environment, his interests turned toward conservation, and he contributed significantly to the efforts of several area organizations devoted to environmental concerns.

Bryan and his wife, Adelaide Richardson Grinnan, have left a significant legacy to us all: a tradition of excellence in medical practice; concern for our people, our community, and our environment; as well as three sons, R. Bryan Grinnan, III, an officer with Sovran Bank in Norfolk; George L.B. Grinnan, MD, a cardiac surgeon in Norfolk; and Richardson Grinnan, MD, chief healthcare management officer, Blue Cross/Blue Shield of Virginia, Richmond. The contributions his sons make to our communities are indicative of Bryan's success as a father and honor his memory.

His last years of practice were spent as a charter member of the newly organized Norfolk Diagnostic Clinic, from whence he retired in October 1978. He continued to play an active role in many of his professional associations after his retirement until his health failed in the past two years, and his long and brilliant career ended in his 81st year on February 20, 1989.

Bryan is survived by his wife of 55 years, his three sons, seven grandchildren, and one great grandchild. Those of us who knew him as a friend and a professional colleague salute him with this tribute.

Memoir of John Lynch 1909-1989

By William H. Harris, Jr., MD, Thomas W. Murrell, Jr., MD, and E. Randolph Trice, MD

John Phillip Lynch was born June 13, 1909, and died July 15, 1989.

Although a native of New Jersey, he was reared in St. Petersburg, Florida, where he graduated from high school in 1926. He continued his education at Washington and Lee University where he received an AB degree summa cum laude in 1930. He was elected to Phi Beta Kappa and was the recipient of the prestigious Algernon Sydney Sullivan Award. His medical degree was earned at the Medical College of Virginia in 1935, where he became a member of Alpha Omega Alpha Honor Medical Society. Dr. Lynch trained at

JOHN PHILLIP LYNCH, MD
1909-1989

the University of Wisconsin and Medical College of Virginia Hospitals. He joined the staff of the McGuire Clinic-St. Luke's Hospital in 1937. Here he remained in the active practice of internal medicine and geriatrics until his retirement in 1984. He was chief of the department of medicine at St. Luke's Hospital from 1962 to 1974 and vice president of St. Luke's Hospital Corporation in 1965.

Throughout his career he taught students at the Medical College of Virginia, where he was on the clinical faculty and from 1953 to 1974 held the rank of assistant clinical professor of medicine. For more than 40 years Dr. Lynch taught student nurses at St. Luke's Hospital. In 1988 he wrote a history of the Nursing School entitled, "One Hundred Fruitful Years."

Dr. Lynch was a man of strong convictions and

superb judgment who was outspoken in support of the causes he espoused and unafraid to express his opinion on controversial matters relating to medical practice. His activities included involvement in local, state, and national medical organizations. He served on many committees in the Richmond medical community.

Dr. Lynch was elected president of the Richmond Academy in 1962 and served as chairman of the board the following year. He championed the cause of medical education and cautioned against too much emphasis on research. He was deeply concerned about the practice of medicine in this country and the training of students in our medical schools. At an Academy meeting he said, "There are many of us who feel that the emphasis on research is being overdone to the detriment of training young men to look after the sick of our communities."

Dr. Lynch was an expert clinician with a broad knowledge of internal medicine who was greatly concerned about the care of the elderly. He believed that older patients need intelligent understanding by physicians as well as therapeutic expertise. He was chairman of the Committee on Aging and Chronic Illnesses of the Medical Society of Virginia from 1961 to 1964 and a member of this Committee from 1979 to 1984. He chaired the Community Study Task Force on Aging for the City of Richmond in 1974. For many years he was an active member and officer of First Presbyterian Church.

Dr. Lynch contributed many papers to various medical journals, primarily VIRGINIA MEDICAL.

His professional memberships included the Richmond Academy of Medicine, Richmond Society of Internal Medicine, Medical Society of Virginia, American Medical Association and the Caduceus Club. He was a diplomate of the American Board of Internal Medicine and a fellow of the American College of Physicians and the American Geriatric Society.

Following his retirement in 1984, he wrote a history of the McGuire Clinic entitled, *The McGuire Clinic: the First Sixty Years (1923-1983)*, which was published in 1987.

This tribute from his McGuire Clinic associates accurately describes the personality and character of John Phillip Lynch:

The McGuire Clinic mourns the passing of one of its leading physicians, shining intellects and history makers. We will miss his sparkling wit, inquisitive mind and his presence. He shared his talents with many committees in the community and on behalf of the medical profession. Dr. Lynch left a legacy we are proud to be part of and anxious to perpetuate.

Dr. Lynch was a devoted husband and father. He is survived by his wife, Helen Davis Lynch, his daughter, Sally Guy Brown, and two grandchildren.

Memoir of J. E. Warren 1915-1989

By William S. Foreman, Jr., MD

Dr. Joseph Edwin Warren, a highly respected obstetrician and gynecologist in Lynchburg, died on Sunday, May 28, 1989.

Born in Hartwell, Georgia, on October 8, 1915, he was the son of the late Mr. and Mrs. Mark T. Warren. Dr. Warren received his premedical education at the University of Georgia in Athens and his medical degree from the University of Georgia School of Medicine in Augusta in 1938. He was a member of the Alpha Omega Alpha honorary medical fraternity. He was licensed to practice medicine in Georgia in 1938.

He served an internship and residency in obstetrics and gynecology at Charity Hospital in New Orleans, Louisiana, from 1938 until 1942. In August 1942 he entered the service of the US Army Air Force and served as a flight surgeon in the Mediterranean theater, attaining the rank of major. For his service he was awarded the Bronze Star. Major Warren was discharged in November 1945.

He was an instructor in obstetrics and gynecology at Louisiana State University from January 1946 through March 1946 and therefore was licensed to practice in Louisiana as well as Georgia and Virginia. He began the private practice of obstetrics and gynecology in Lynchburg in May 1946, where he continued to have an open ear and heart for his many devoted patients until retirement.

Dr. Warren was a member of the American Medical Association, a fellow of the College of Obstetrics and Gynecology, a diplomate of the American Board of Obstetrics and Gynecology and a member of The Medical Society of Virginia, the American Medical Association, the South Atlantic Association of Obstetricians and Gynecologists, and the staffs of Virginia Baptist and Lynchburg General-Marshall Lodge Hospitals. He was a member of the First Presbyterian Church.

He is survived by his wife, Anne Comolli Warren, one son, Joseph Alex Warren of Lynchburg, and two grandsons.

COMMITTED TO EXCELLENCE

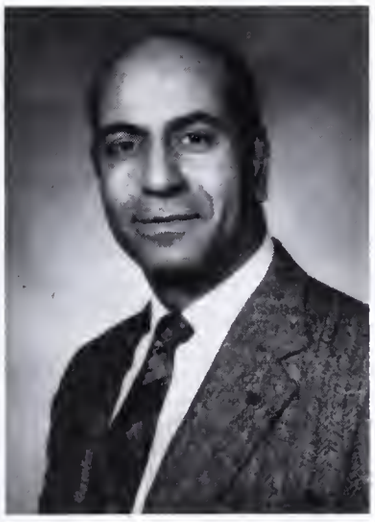
ROCHE

PRESIDENT'S ACHIEVEMENT AWARD

Presenting the winners of the 1989 Roche President's Achievement Awards

Roche Laboratories is proud to honor these outstanding sales representatives, chosen for their unparalleled dedication to the healthcare field, professionalism and consistent high level of performance. Please join us in congratulating these exceptional individuals.

Kathy Mortez-Hagy



Mohamed E. Nouh

Eric W. Spangler

Turn to the following page and find out how your award-winning Roche representative can help both you *and* your patients.

Your Roche Representative Would Like You To Have Something That Will...

ROCHE®

... improve patient satisfaction with office visits.
... improve patient compliance with your instructions.
... reduce follow-up calls to clarify instructions.

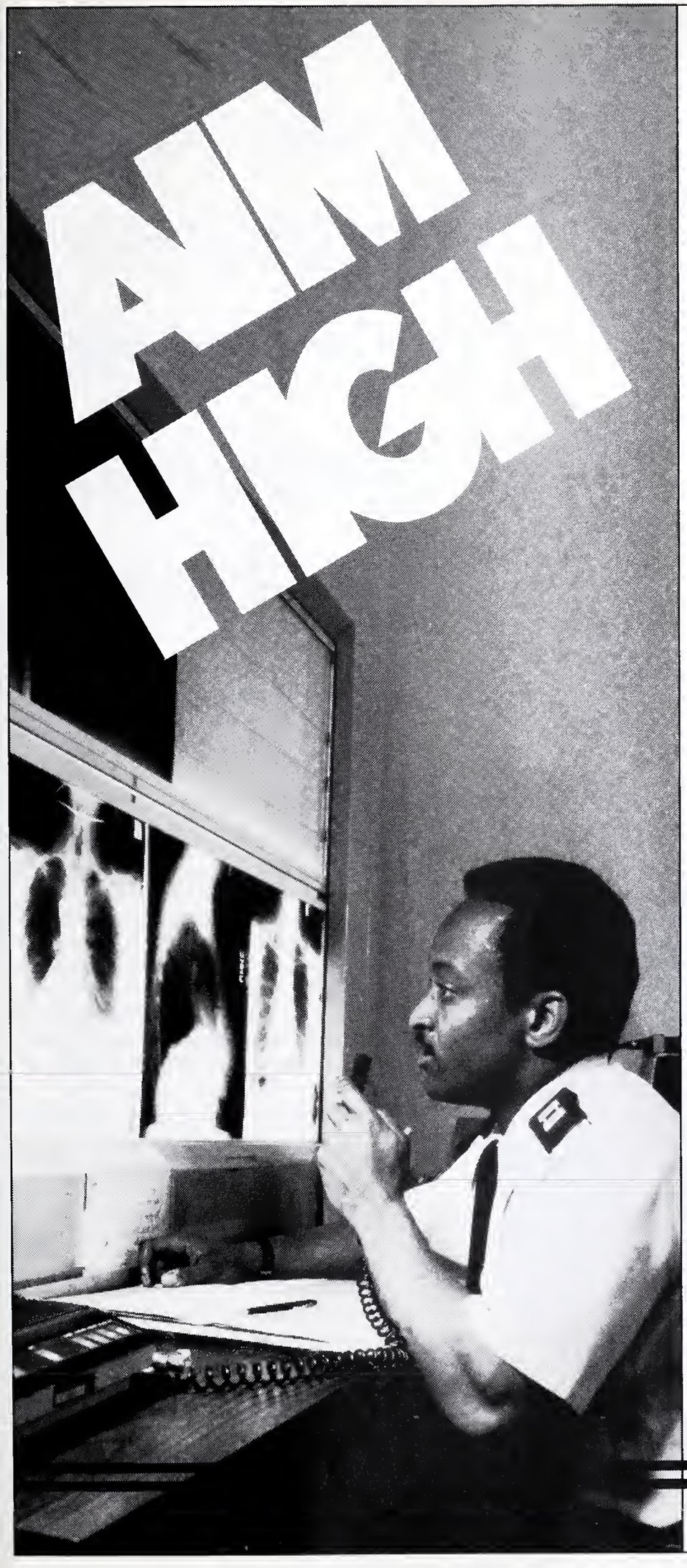
Roche product booklets ...

- offer a supplement to, not a substitute for, patient contact.
- support your specific instructions to the patient.
- provide a long-term reinforcement of your oral counseling.
- are available in *Spanish*.

Because you are the primary source of medical information for your patients, we invite you to look over the Roche product booklets shown below. Ask your Roche representative for the new catalog brochure of patient education materials and for a complimentary supply of those booklets applicable to your practice, including the WHAT IF Book in large type.

ROCHE ME MEDICATION EDUCATION

Working today for a healthier tomorrow



SPECIALIZE IN AIR FORCE MEDICINE.

ER Physicians. Radiologists. OB/GYNs and other specialists! Today's Air Force gives you the freedom to specialize without the financial overhead of running a private practice. Talk to an Air Force medical program manager about the tremendous benefits of becoming an Air Force medical officer:

- No office overhead
- Dedicated, professional staff
- Quality lifestyle and benefits
- 30 days vacation with pay each year

Examine your future in the Air Force. Learn if you qualify. Call

USAF HEALTH PROFESSIONS
804-276-0459
Station-To-Station Collect

AIR FORCE

MEETINGS

May 3-6
Annual Meeting of the Virginia Chapter, American College of Radiology, the Homestead, *Hot Springs*. Patricia R. Berry, 703-669-8312.

May 4
Reimbursement Seminar: Getting Your Fair Share (Virginia Chapter, American College of Emergency Physicians), *Fredericksburg*. Gwen E. Messler Harry, 804-966-5966.

May 4-6
10th Annual Clinical Concerns in Primary Care (Medical College of Virginia/VCU), *Williamsburg*. CME Office, 804-786-0494.

May 5
Nutritional Support of the Trauma Patient (Fairfax Hospital), *Falls Church*. Cathy Sarraf, 703-698-2572.

May 8
8th Annual Ethics Symposium: The Dilemma of Fetal Viability—Medical and Legal Impact on the Delivery of Health Care (Fairfax Hospital), *Falls Church*. Cathy Sarraf, 703-698-2572.

May 10-13
Annual Meeting, Virginia Orthopaedic Society, *Wintergreen*. Donna Scott, 804-353-2721.

May 14-18
Topics in Clinical Medicine (Johns Hopkins), *Baltimore*. 40 credit hrs. Fee, $650. CME Office, 955-2959.

May 25-27
Advances in Pediatrics (American Academy of Pediatrics), *Hilton Head Island, South Carolina*. 16 credit hrs. CME Registration, 800-421-0589.

May 26-28
11th Annual Urogynecology and Pelvic Surgery (Medical College of Virginia/VCU), *Williamsburg*. CME Office, 804-786-0494.

May 29-June 1
19th Annual Educational/Scientific Symposium (Society of Critical Care Medicine), *San Francisco*. 34 credit hrs. Lisa Parks, 714-870-5243.

June 3-10
Reproductive Endocrinology and General Gynecology (Johns Hopkins), *Hilton Head Island, South Carolina*. 33 credit hrs. Office of CME, 301-955-2959.

June 4-8
6th Edition, Family Medicine Review Course (Eastern Vir-

HERE'S ONE CASE OUR ADDICTION SPECIALISTS RARELY SEE.

You could probably say we've seen it all at the University Center for Addictive Behavior. Our patients range from the abuser to the severely addicted; from the adolescent to the older adult.

But even with our diverse caseload, you'll hardly ever see anyone being admitted to the hospital. Because we help patients overcome their problems without hospitalization, through comprehensive programs, which are conducted on an outpatient basis. Even chemical withdrawal can be done without the patient being admitted.

Of course, sometimes a patient will need to be hospitalized. We can arrange to do so on a short-term basis, until those patients are ready for one of UCAB's out-patient programs, exclusively staffed by MCV faculty.

If you know someone who needs addictions treatment, no matter how slight or how severe their problem, call UCAB. We're here to help stop their addiction. Case closed.

M C V UCAB HOSPITALS

Conveniently located in the West End. The Forum Executive Center, 10124 West Broad Street, Glen Allen, Virginia, (804) 662-7172

ginia Medical School), *Virginia Beach*. CME Office, 804-446-6140.

June 4-8
General Surgery Seminar: Update and Review (Lloyd Noland Hospital), *Hilton Head Island, South Carolina*. CME Office, 205-783-5276.

June 6-10
7th Annual Meeting of the Southern Orthopaedic Association, *Maui, Hawaii*. Kathy McLendon, 205-945-1848.

June 7-9
Update in Obstetrics (American College of Obstetricians/Gynecologists), *Norfolk*. 16 credit hrs. Fee, $515. ACOG Registrar, 800-673-8444.

June 7-10
14th Annual Postgraduate Course on Rehabilitation of the Brain-Injured Adult and Child (Medical College of Virginia/VCU), *Williamsburg*. CME Office, 804-786-7290.

June 11-15
Adult Infectious Disease Seminar: Current Update (Lloyd Noland Hospital), *Hilton Head Island, South Carolina*. CME Office, 205-783-5276.

June 14-16
35th Annual Great Smokey Mountains Pediatric Seminar (University of Tennessee), *Gatlinburg, Tennessee*. Abby Hall, 615-544-9190.

June 15-16
Arrhythmnias: Interpretation, Diagnosis and Management (Medical Education Resources), *Williamsburg*. Deborah Helton, 800-421-3756.

June 20-23
Second Baltimore Perinatal Colloquium (Johns Hopkins/University of Maryland), *Baltimore*. 24 credit hrs. Office of CME, 301-955-2959.

June 21-24
Annual Meeting, Virginia Society of Ophthalmology, *Norfolk*. Donna Scott, 804-353-2721.

June 22-24
Clinical Pediatrics (American College of Pediatrics), *Washington, DC*. 16 credit hrs. CME Registration, 800-421-0589.

June 24-27
17th Annual Harvard Medical School Course on Interstate Care Medicine: The Art and Science of Critical Care, *Boston Massachusetts*. Bart Chernow, MD, 617-726-2858.

June 26-30
Family Practice Seminar: Update and Review (Lloyd Noland Hospital), *Hilton Head Island, South Carolina*. CME Office, 205-783-5276.

JUNE 16

10th ANNUAL ADVANCES IN GASTROENTEROLOGY

BALLY'S PARK PLACE

ATLANTIC CITY, NEW JERSEY

For further information, contact:

Registration Manager
SLACK Incorporated
6900 Grove Road
Thorofare, N.J. 08086
609-848-1000

SERIAL LEARNING PROGRAMS

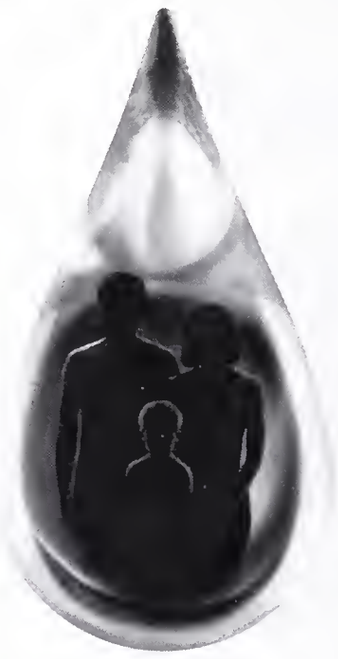
Colby College in Waterville, Maine, has presented continuing medical education courses since 1945, building a national reputation for courses of quality in a pleasurable summer milieu. Physicians and their families are accommodated on campus. The courses offered in 1990 are listed below; all are accredited for Category I. For further information, write or call Robert H. Kany, Director of Special Programs, Colby College, Waterville ME 04901, 207-872-3000.

June 17–29, Orthopedics; 60 credit hrs; tuition, $1000
June 24–29, Family Practice, 26 hours, $400
July 8–11, Addiction Medicine, 14 hrs, $360
July 9–10, Child Abuse, 12 hrs, $150
July 9–13, Allergy/Asthma/Dermatology, 18 hrs, $400
July 9–13, Pediatrics, 16 hrs, $400
July 15–17, Gastroenterology, 12 hrs, $300
July 17–20, Urology, 15 hrs, $375
July 17–20, Surgical Techniques, 15 hrs, $400
July 22–26, Ophthalmology, 18 hrs, $450
July 23–27, Anesthesiology, 15 hrs, $375
July 29–August 3, Obstetrics/Gynecology, 22 hrs, $500
July 30–August 2, Diabetes, 15 hrs, $375
July 30–August 3, Otolaryngology, 18 hrs, $450
August 12–16, Emergency Medicine, 24 hrs, $400
August 12–16, Forensic Medicine, 34 hrs, $400

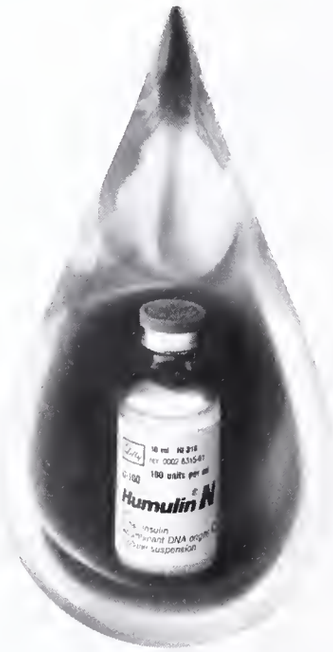
For treatment of diabetes:

Introducing
Humulin® 70/30
70% human insulin isophane suspension
30% human insulin injection
(recombinant DNA origin)

REPLACE
Human Insulin



With Human Insulin



Humulin®
human insulin
(recombinant DNA origin)

Any change of insulin should be made cautiously and only under medical supervision.

Lilly Leadership In Diabetes Care

© 1989, ELI LILLY AND COMPANY HI-2914-B 949334

VIRGINIA MEDICAL CLASSIFIED

Virginia Medical classified ads accepted at the discretion of the Editor. Rates to Medical Society of Virginia members: $15 per insertion up to 50 words, 25¢ each additional word. To non-members: $30 per insertion up to 50 words, 25¢ each additional word. Deadline: 5th day of month prior to month of publication. Send to the Advertising Manager, 4205 Dover Road, Richmond VA 23221.

RICHMOND Virginia—B/E Family Practitioner desires office work full-time July and August 1990, Richmond or suburbs. No hospital work. Do you and your partners need vacation coverage? Contact Dr. T. J. Wade, 8408 Bronwood Road, Richmond, Virginia 23229. Telephone 804-270-1687.

FOR SALE—Used medical equipment, almost like new. 1) EKG machine, automatic, single channel, Burdick, used 10 months, originally $2148, now $1300. 2) Three wall-mounted Welch-Allen otoscope/ophthalmoscope combinations with transformers, originally $1175, asking $250 for each unit or $750 total. Call 804-355-7353 (Richmond).

FAMILY PRACTICE on Chesapeake Bay—Owner retiring. Start enjoying medicine again. Four day work week, no HMO, PPO, or Medicaid. Join owner and take over practice in one to two years. Send reply to Va Med Box 133, 4205 Dover Road, Richmond VA 23221.

AVAILABLE—Cardiologist: American born/trained; 42; board-certified; experienced in PTCA, cath, echo/Doppler, critical care, clinical skills; Master's degree in Education; seeking private or institutional position in/near metropolitan area in VA. Please contact Raymond Vergne, MD 1000 Grandview Ave, Pittsburgh PA 15211; 412-621-4179 office, 412-431-0977 evenings.

OCEANFRONT COMPLEX on Topsail Island, NC—Second row 3-bedroom, 2½-bath with oceanview. Fully equipped. Pool. Sleeps 8. On/off season rentals. Paul & Susan Levine, 804-973-4732.

SANDERLING SALE, Duck, N.C.—Beach cottage by owner. 4/5 bedrooms, 2½ baths, less than fifty yards from ocean across boardwalk, excellent rental history, $325,000, financing available. 804-794-7600 (W), 804-794-9061 or 804-272-6240 (H).

FOR SALE—General Electric Maximar 100 for superficial therapy with all filters and cones and rail for mounting. In excellent condition. Call Allen Peple, MD, 804-648-1052 (Richmond).

UNSECURED LOANS for physicians. Call Dr. Gerald Sacks, 703-751-3226.

ATTENTION

Lewis-Gale Clinic Is Expanding

Ownership/Employment for Physicians in

Cardiology
Plastic, Reconstructive & Cosmetic Surgery
Orthopaedic
Rheumatology
Family Practice
Radiology
Neurology

Founded in 1909, Lewis-Gale Clinic is owned by 96 practicing physicians representing 23 specialties with a 5-to-1 ratio of support personnel per physician. The Clinic's seven locations are in the beautiful Roanoke Valley (pop. 225,000), a 4-hour drive from D.C. The Main Clinic in Salem is conveniently adjacent to a 406-bed hospital. Excellent facilities and working environment.

Send C.V. and references to:

Julie Lusk, Lewis-Gale Clinic,
1802 Braeburn Drive, Salem VA 24153

PHP HEALTHCARE CORPORATION

PHYSICIAN OPPORTUNITY

PHP Healthcare Corporation, a leader in healthcare management services, has an immediate need for physicians to staff primary care clinics in **Northern Virginia** and **Jacksonville, NC;** other immediate openings in Jacksonville and Fayetteville, North Carolina, and Columbus, Georgia. *Qualifications; BC/BE, appropriate state licensure.*

Our company offers:

- An outstanding incentive pay plan;
- Paid malpractice insurance;
- A pleasant work environment;
- No on-call coverage;
- Flexible scheduling arrangements;
- Stimulating, professional practice free from administrative burdens.

If interested and qualified, please call or send to:

LEIGH ROBBINS
PHP HEALTHCARE CORPORATION
7044 NORTHRIDGE DRIVE
NASHVILLE, TENNESSEE 37221
— 615/662-1310

EMERGENCY ROOM & AMBULATORY CARE CLINIC PHYSICIANS

PHP HEALTHCARE CORPORATION, a leader in healthcare management services, has a potential need for physicians to staff an emergency room & ambulatory care clinic (EMAC) in JACKSONVILLE, NC and OCEANSIDE, CA. We also have IMMEDIATE openings in a primary care clinic in JACKSONVILLE and FAYETTEVILLE, NC (operated under the name of NAVCARE and PRIMUS).

Emergency Room qualifications include:
- BE/BC in Emergency Medicine
- ATLS, ACLS, BLS, DEA number
- current state licensure

Ambulatory Care Clinic qualifications include:
- ACLS, BLS, DEA number
- current state licensure

PHP provides paid malpractice insurance and excellent compensation. If interested, please call or send CV to:

Leigh Robbins
PHP HEALTHCARE CORPORATION
7044 Northridge Drive
Nashville, TN 37221
(615)662-1310

EOE, m/f

DIRECTORY OF ADVERTISERS

Birkdale Realty 179
Charleston Area Medical Center 148
Clements & Company 151
Health of Virginia 175
Eli Lilly & Company 176
Medical Protective Company 149
Merck, Sharp & Dohme ..... Covs 3, 4
PHP Healthcare 177, 178
Palisades Pharmaceuticals 180
John P. Pearl & Associates 143
Peoples Drug Stores 139
Richmond Headache Center 151
Roche Laboratories 140, 171-172
Sentient Systems, Inc. 137
Sheppard & Enoch Pratt 150
Slack, Inc. 175
United States Air Force 173
United States Army Reserve ..... Cov 2
University Center for Addictive Behavior 142
Virginia Insurance Reciprocal 158-159

PHYSICIANS WANTED—Family physician or internist for office and hospital practice in the greater Richmond area. There is also an opening for a semi-retired physician for part-time work. Inquiries held strictly confidential. Send CV and financial requirements to Va Med Box 131, 4205 Dover Road, Richmond VA 23221.

SURGEON—85-bed hospital in rural Northwestern Pennsylvania seeking additional general surgeon. Salary of $100,000, office overhead, malpractice, other benefits. Call: Wanda Parker at 1-800-221-4762, or collect, 212-599-6200. E. G. Todd Associates, 535 Fifth Avenue, New York, NY 10017.

WASHINGTON DC—Internist BC/BE to join young, busy internist in Virginia suburbs of Washington DC. Strong commitment to primary care required. Excellent salary, benefits and partnership pathway. Send CV and cover letter to VA Med Box 132, 4205 Dover Road, Richmond, VA 23221.

PEDIATRICIAN—85-bed hospital in rural Northwestern Pennsylvania seeking additional Pediatrician. Salary of $75,000, office overhead, malpractice, other benefits. Call: Wanda Parker at 1-800-221-4762, or collect 212-599-6200. E. G. Todd Associates, 535 Fifth Avenue, New York, NY 10017.

POSITIONS AVAILABLE in Virginia Beach and surrounding cities—Sentara Medical Care Centers, a subsidiary of Sentara Health Systems, Virginia's premier health care network, are seeking BC/BE physicians to staff its Centers. Family practice opportunities also available. Flexible hours, competitive compensation package, incentive programs available. Excellent recreational, cultural, and educational area. Send CV to Gail Billups, Sentara Medical Care Centers, 22 Koger Executive Center, Suite 202, Norfolk, Virginia 23502 or call collect 804-466-9187. An Equal Opportunity Employer.

CENTRAL PA—177-bed, south central Pennsylvania hospital seeking board certified/eligible emergency physician. 21,000 ED visits/year. Salary of $100,000, 4 weeks vacation, 2 weeks CME. Call: Wanda Parker at 1-800-221-4762, or collect, 212-599-6200. E. G. Todd Associates, 535 Fifth Avenue, New York, NY 10017.

MEDICAL OFFICE for rent—West Springfield, Va. Professional park in upper middle-class community of Fairfax County. 950 square feet. Three exam rooms, reception office, business office, lab, bath. On hall with 4 other doctors. Ideal for any practice. No CPI increase $1070/month lease. Call Dr. Robert DeAngelis, 703-451-8777, for details.

WESTERN NY—102-bed hospital in Western New York, offering cash collected first-year minimum income of $80,000, 6 months office overhead, and malpractice. OB/GYNs provide subspecialty backup. Possible University affiliation. Call: Wanda Parker at 1-800-221-4762, or collect 212-599-6200. E. G. Todd Associates, 535 Fifth Avenue, New York, NY 10017.

TWO-STORY HOME—Beautifully restored two-story home situated on 2.2 acres overlooking Nomini Creek, 8 feet depth at end of pier, wild life park on opposite shore, large trees surround home, 4 bedrooms, 2½ baths, large dressing room in master bedroom, 35×14 living room, 23×14 dining room, slate entrance foyer, beautiful pine paneling with exposed

OUR HOME SALES ARE ON THE UPSWING.

Bert Hodson

Swing by the 500-acre golf course community of Birkdale, and you'll see why so many people wouldn't live anywhere else. Each of our homes is a perfect example of quality craftsmanship, whether traditional, Victorian, or contemporary.

Over half of them offer views of the lake and fairways. And they all offer access to the tennis, swimming, and tree-lined paths for biking, walking, or jogging.

Of course, one of the main attractions is our Dan Maples-designed championship golf course. A full-service practice range and our daily fee golf course will be open for your inspection, along with our homes.

Call us at our Information and Sales Center—(804) 739-0301 today. Here at Birkdale, the quality of English country living will always be in full swing.

Birkdale

Directions: Drive 2 miles on Rte. 360 west of the 288 Interchange, then turn left on Winterpock Road for one mile to Birkdale.

EQUAL HOUSING OPPORTUNITY

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85

AVAILABLE AT PHARMACIES NATIONWIDE

PALISADES PHARMACEUTICALS, INC.
219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

beams, sun porch and sun room. Guest cottage and outdoor brick grill. Priced $25,000 below value. Contact J. Shapiro, MD, 703-752-4480.

NORTHWESTERN PA—85-bed hospital in rural Northwestern Pennsylvania seeking additional orthopedic surgeon for rapidly growing practice. Salary of $130,000, malpractice, other benefits. Call: Wanda Parker at 1-800-221-4762, or collect, 212-599-6200. E. G. Todd Associates, 535 Fifth Avenue, New York, NY 10017.

FAMILY PRACTICE—Pennsylvania practice-solo, with 4 other Family Practitioners for call. Cash collected first-year minimum income guarantee of $85,000, first 6 months office overhead fully paid. 104-bed hospital, 43,000 annual admissions, 37-member staff. Call: Wanda Parker at 1-800-221-4762, or collect, 212-599-6200. E. G. Todd Associates, 535 Fifth Avenue, New York, NY 10017.

RICHMOND, Virginia—Seeking residency-trained physicians for full-time and part-time emergency department opportunities. Two facilities with a combined patient volume of 50,000 plus provides excellent medical and surgical back-up. Double coverage provided during peak periods. Excellent compensation and paid malpractice insurance. Benefit package available for full-time physicians. For more information contact: Betty Albrecht, Emergency Consultants, Inc., 2240 S. Airport Road, Room 40, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

GRAND CAYMAN PARADISE—Luxury condo on Seven Mile Caribbean Beach, includes tennis court, bicycles, 2 pools, Jacuzzi, and Sunfish at the beach. 2-bedroom unit, last 2 weeks of August at $1000/week or $1800 both weeks. 3-bedroom unit, last 2 weeks of July, $1200/week or $2200 both weeks. Scuba, snorkel, sailing, fishing, golf all nearby. Dr. Jay Buston, 804-266-7613 or 804-272-7849.

HOLTER RECORDERS provided to physician's offices at no charge. Virginia Heart Institute's services includes scanning, analysis and interpretation of Holter 24-hour ambulatory recordings. Call 804-359-9265 or in Virginia 1-800-468-1030.

WINTERGREEN RENTAL—Cliffs Condominiums, two bedroom, two bath, overlooking entire Wintergreen village near top of the expert slope. Rates are substantially less than through Wintergreen's front desk. Call Thomas Shuttleworth at 804-431-3100 or write 2809 S. Lynnhaven Road, Virginia Beach VA 23452.

APPRAISALS & SALES—The specialists in on-site practice valuations and transfers to physicians, hospitals and investors. Please contact: Ed Strogen, Fulton, Longshore & Associates, Inc., 527 Plymouth Road, Suite 410, Plymouth Meeting PA 19462; 215-834-6780 or 1-800-346-8397.

FARMVILLE, Virginia—Seeking full-time and part-time physicians for hospital located 1 hour west of Richmond. Excellent compensation, full malpractice insurance coverage, and benefit package to full-time staff. Contact: Betty Albrecht, Emergency Consultants, Inc., 2240 S. Airport Road, Room 40, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

VASOTEC®

(ENALAPRIL MALEATE | MSD)

VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed, caution should be observed when initiating therapy (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary

Neutropenia/Agranulocytosis Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered

Precautions: *General. Impaired Renal Function* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy In such patients, renal function should be monitored during the first few weeks of therapy

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia Elevated serum potassium (>5 7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions.*)

Surgery/Anesthesia In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion

Information for Patients

Angioedema Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician

Hypotension Patients should be cautioned to report lightheadedness, especially during the first few days of therapy If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician

Hyperkalemia Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia Patients should be told to report promptly any indication of infection (e g., sore throat, fever) which may be a sign of neutropenia

NOTE As with many other drugs, certain advice to patients being treated with enalapril is warranted This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects

Drug Interactions

Hypotension. Patients on Diuretic Therapy Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e g., diuretics).

Other Cardiovascular Agents VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium. VASOTEC attenuates potassium loss caused by thiazide-type diuretics Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amilcride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy – Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose)

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women However, data are available that show enalapril crosses the human placenta Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSO) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use Safety and effectiveness in children have not been established

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients

HYPERTENSION The most frequent clinical adverse experiences in controlled trials were headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE The most frequent clinical adverse experiences in both controlled and uncontrolled trials were dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category

Cardiovascular Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); pulmonary embolism and infarction, pulmonary edema, rhythm disturbances, atrial fibrillation, palpitation.

Digestive: Ileus, pancreatitis, hepatitis (hepatocellular or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth

Musculoskeletal: Muscle cramps

Nervous/Psychiatric Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and OOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection

Skin Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, hyperhidrosis

Special Senses: Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, tearing

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgias/arthritis, myalgias, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0 2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately (See WARNINGS)

Hypotension In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy Hypotension or syncope was a cause for discontinuation of therapy in 0 1% of hypertensive patients In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2 2% of patients Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure (See WARNINGS)

Clinical Laboratory Test Findings

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0 2% of patients with essential hypertension treated with VASOTEC alone Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1 2% of patients

Hemoglobin and Hematocrit. Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists In clinical trials, less than 0.1% of patients discontinued therapy due to anemia

Other (Causal Relationship Unknown) In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency

Liver Function Tests Elevations of liver enzymes and/or serum bilirubin have occurred

Dosage and Administration: *Hypertension:* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS) It the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed

If the diuretic cannot be discontinued, an initial dose of 2 5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour (See WARNINGS and PRECAUTIONS, *Drug Interactions*)

The recommended initial dose in patients not on diuretics is 5 mg once a day Oosage should be adjusted according to blood pressure response The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered If blood pressure is not controlled with VASOTEC alone, a diuretic may be added

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment The usual dose of enalapril is recommended for patients with a creatinine clearance > 30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤ 30 mL/min (serum creatinine ≥ 3 mg/dL), the first dose is 2.5 mg once daily The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily

Heart Failure VASDTEC is indicated as adjunctive therapy with diuretics and digitalis The recommended starting dose is 2.5 mg once or twice daily After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects.*) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Patients with Heart Failure and Renal Impairment or Hyponatremia In patients with heart failure who have hyponatremia (serum sodium < 130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See OOSAGE AND ADMINISTRATION, *Heart Failure,* WARNINGS, and PRECAUTIONS, *Drug Interactions.*) The dose may be increased to 2.5 mg b i.d., then 5 mg b.i.d and higher as needed, usually at intervals of four days or more, it at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg

For more detailed information, consult your MSD Representative or see Prescribing Information, Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486. J9VS61R2(819)

MSD
MERCK SHARP & DOHME

THERAPY THAT MAY BE AS SILENT AS HYPERTENSION ITSELF

VASOTEC is generally well tolerated and not characterized by certain undesirable effects associated with selected agents in other antihypertensive classes.

VASOTEC is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

A diminished antihypertensive effect toward the end of the dosing interval can occur in some patients.

For a Brief Summary of Prescribing Information, please see the last page of this advertisement.

FOR MANY HYPERTENSIVE PATIENTS
ONCE-A-DAY

VASOTEC®
(ENALAPRIL MALEATE | MSD)

Copyright © 1990 by Merck & Co., Inc.

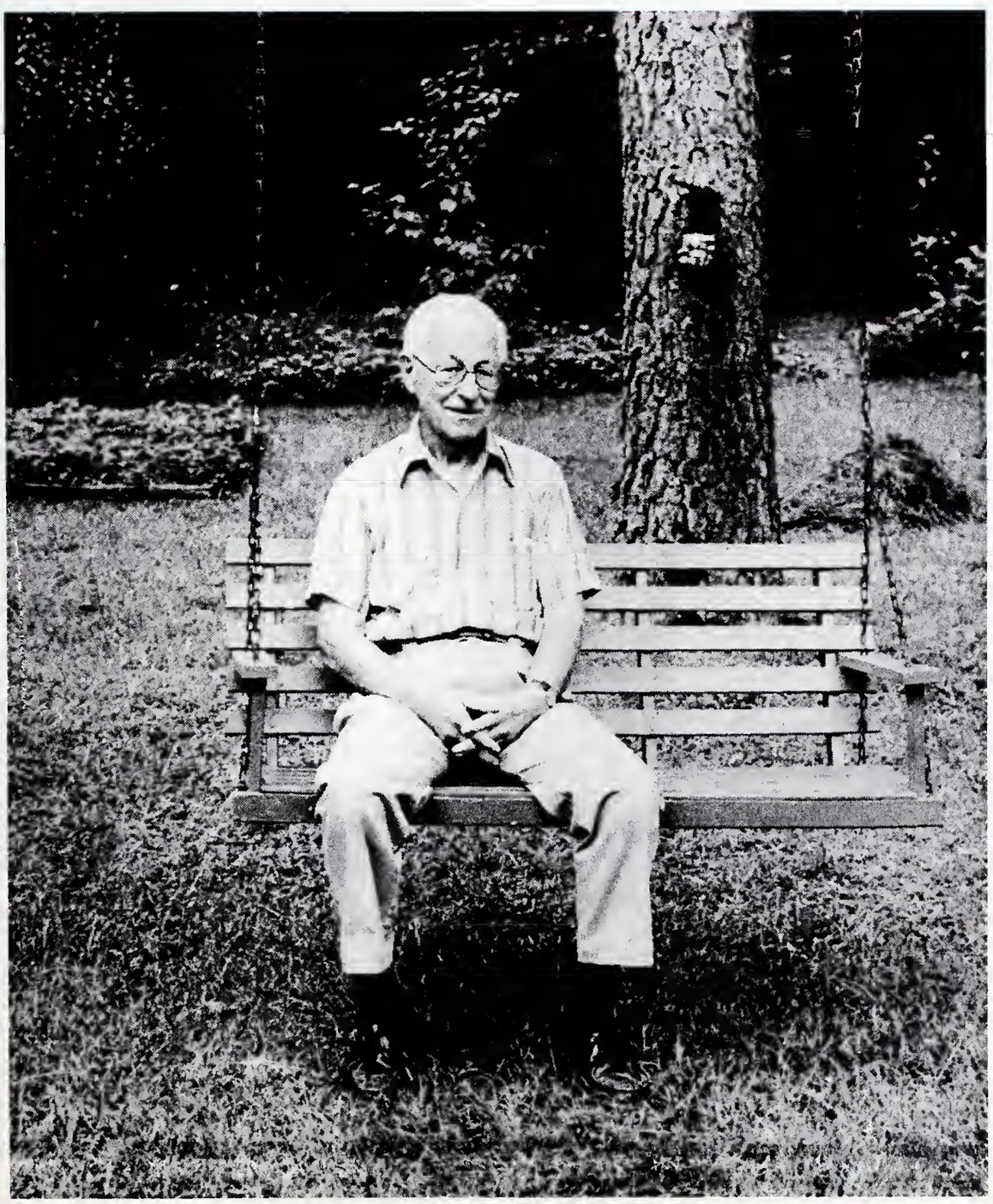
VIRGINIA MEDICAL

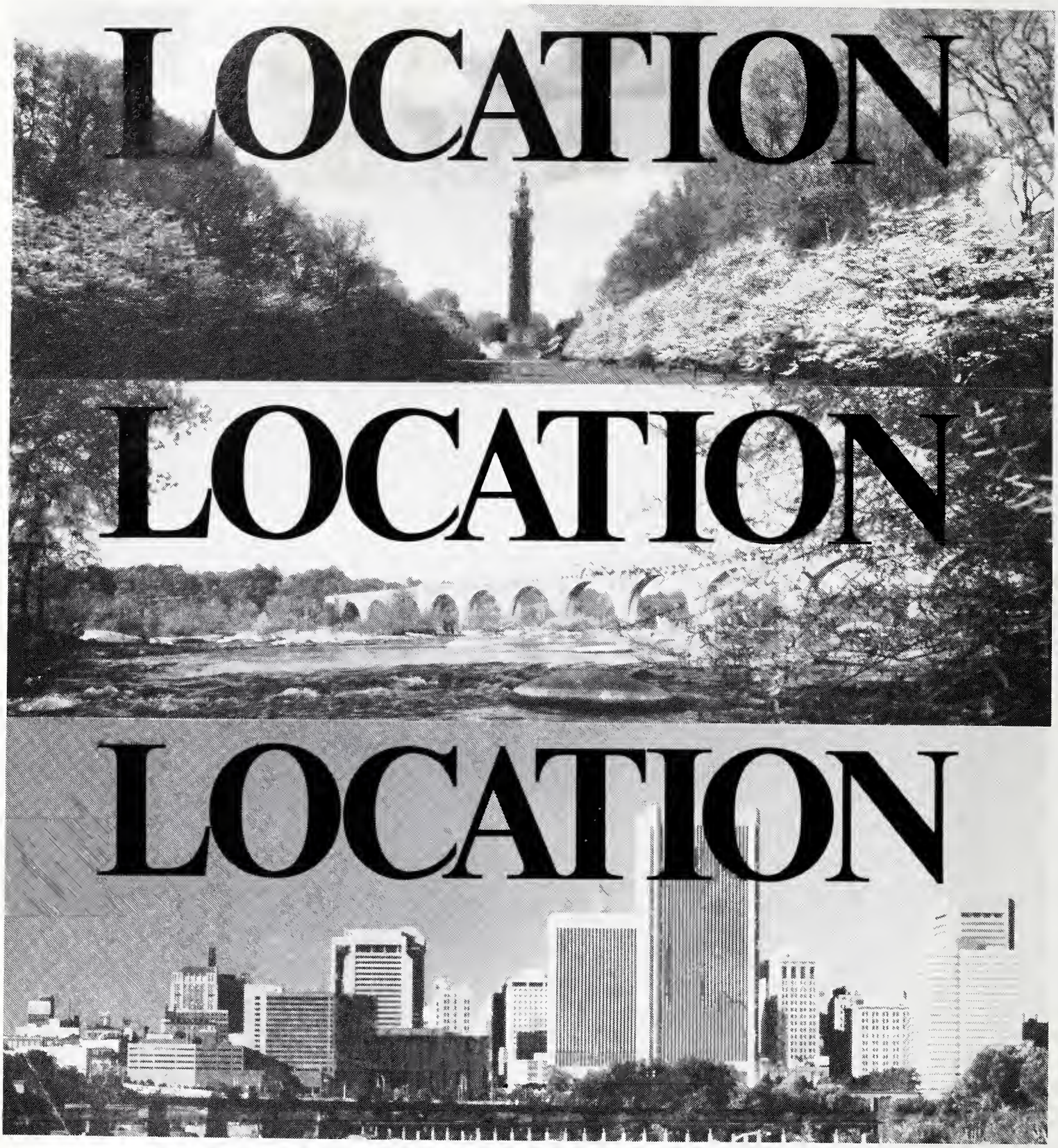
CURRENT
JNLS
W1
VI
799J

Virginia Medical
UCSF LIBRARY
Received on: 05-30-90

May
1990

The Award Winning Publication of The Medical Society of Virginia





Location means everything when it comes to Kanawha Trace.

Location is our spectacular setting overlooking the James. Location is living in the city, less than five minutes from the heart of downtown. It's Maymont. The Carillon. Dogwood Dell. Byrd Park. It's also living in award-winning, natural surroundings that afford only the finest in lifestyles.

EQUAL HOUSING OPPORTUNITY

KANAWHA TRACE

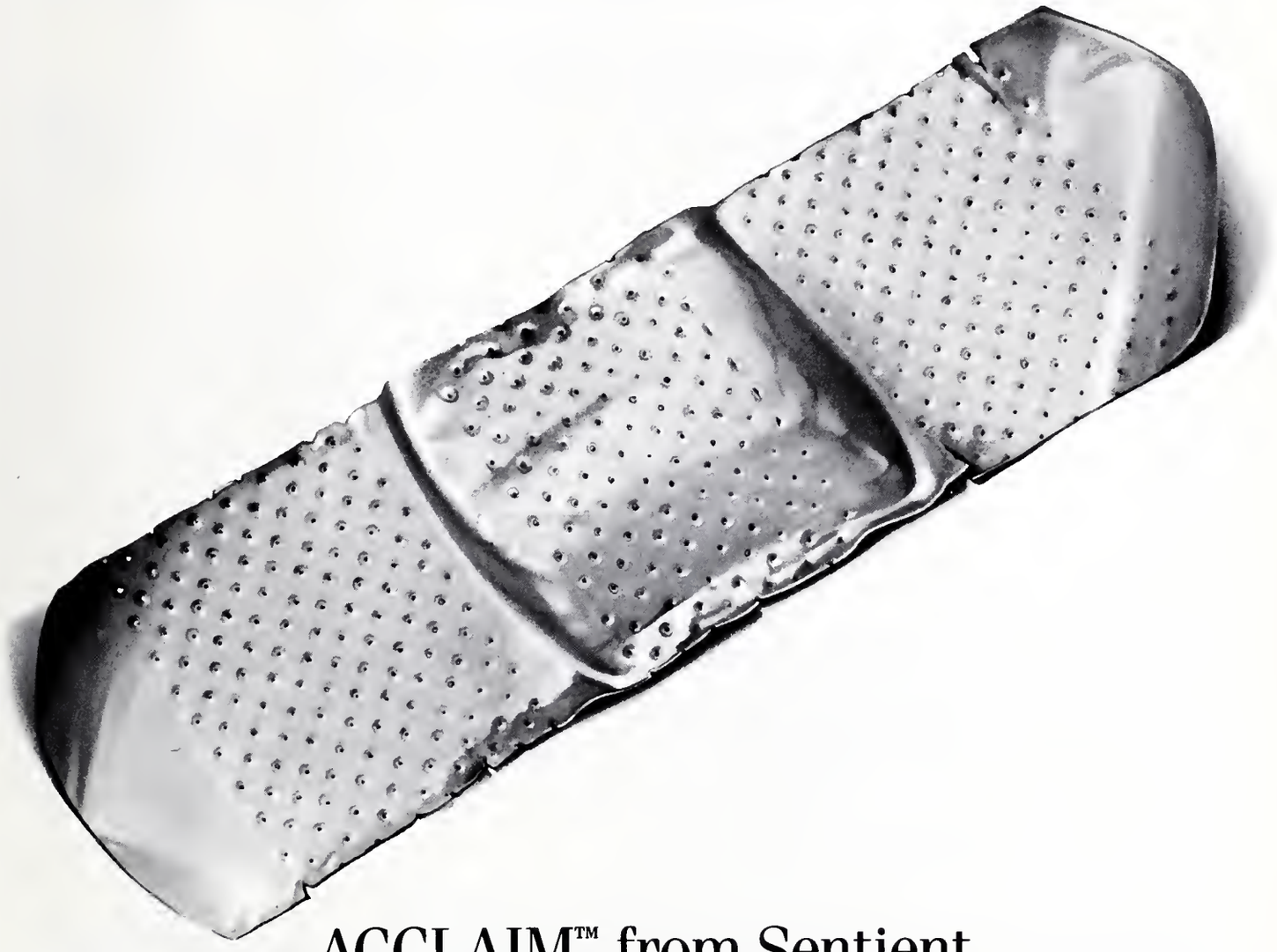
Location. It is everything...and we've got it right here. Kanawha Trace—a distinctly different approach to downtown living.

Come by and see us today—we're right in the neighborhood.

Take Boulevard south, right on Pumphouse Road, left on James River Falls Drive. 355-4100. Exclusively represented by Muhleman & Company, Inc., Realtors. 359-8181.

REALTOR®

Why buy an office automation system that doesn't offer a long-term solution?



ACCLAIM™ from Sentient is the total system solution.

A lot of medical practices are planning to invest in an office automation system. But a lot of the systems out there just don't offer the comprehensive functions and long-term expandability that your practice may need.

IBM® and compatible hardware.

The ACCLAIM system operates on IBM and compatible hardware, so you know you're getting the quality standard of the industry. And it's completely expandable, so it can grow as your practice grows.

Long-term support.

ACCLAIM is the system solution that fits your needs today. And Sentient's software engineers, customer trainers, and telephone support people are always there to make sure your system fits your needs over the years to come.

Easy to operate.

Even if your staff has no previous computer experience, ACCLAIM is simple to operate effectively and efficiently. Complete training is included in the purchase.

When you're thinking about office automation, call Sentient first, and find out what ACCLAIM can do for you.

1-800-247-9419
(In the D.C. Metro area call 1-301-929-7600.)

SENTIENT
SYSTEMS

We set the standard in medical computing.

VIRGINIA MEDICAL

May 1990, Volume 117, Number 5

© 1990—The Medical Society of Virginia

RETIREMENT

On the cover **Dr. John A. Murray, retired**

196 **Who's Who:** Retirements

194 **How to Sell a Solo Practice**

Cover photo by Jim Hekel for the *Tidewater News*

MEDICINE

204 **Acute Rheumatic Fever: Is It Returning to Virginia?**
Michael B. Lenhart and Duncan S. Owen, Jr.

206 **Ankylosing Hyperostosis of the Spine: Case Report**
L. Ormandy and R. G. Riddick

207 **Bilateral Tubal Pregnancy: Case Report**
Fadi A. Bsat and Sidath Jayanetti

209 **Abstracts from the Annual Meeting of the Virginia Dermatological Society**

EDITORIALS

215 **Changes** E. L. Kendig, Jr.

215 **The Hawk** H. S. Campell

HISTORICAL NOTES

216 **How We Got Here: Case Report from the Class of 1904**
Lockhart B. McGuire

186 **Letters to the Editor**

190 **New Medical Society of Virginia Members**

193 **Meetings about Medicine**

219 **Medical Society of Virginia Officers**

220 **Obituary**

222 **Classified Advertisements**

Editor Edwin L. Kendig, Jr., MD
Associate Editors Richard G. Lester, MD; Duncan S. Owen, Jr., MD; John A. Owen, Jr., MD
Editorial Board H. C. Alexander III, MD; Raymond S. Brown, MD; Henry S. Campell, MD; C. Barrie Cook, MD; Eloise C. Haun, MD; Walter Lawrence, Jr., MD; Lockhart B. McGuire, MD; Robert Edgar Mitchell, Jr., MD
Executive Editor Ann Gray Senaida Sayre, Assistant
Business Manager James L. Moore, Jr.

DISCLAIMER: Advertisements in VIRGINIA MEDICAL for products, services, courses and symposia are published with a "buyer beware" understanding. The Publisher, the Editor and members of the Editorial Board do not imply warranty of products, nor endorsement of offered educational material.

VIRGINIA MEDICAL (ISSN 0146-3616) is the monthly publication of The Medical Society of Virginia. Second-class postage paid at Richmond, Virginia. Yearly subscription rate: $24 domestic, $30 foreign; single copies, $3. VIRGINIA MEDICAL does not hold itself responsible for s atements made by any contributor. The publisher reserves the right to reject any advertisement. For information on the preparation of articles, write to the Executive Editor for "Advice to Authors," or call (804) 353-2721. POSTMASTER: Send address changes to VIRGINIA MEDICAL, 4205 Dover Road, Richmond VA 23221.

ANNOUNCING

The NEW Individual Non-Cancellable Disability Program

Endorsed by
Medical Society of Virginia

- **Guaranteed renewable**
- **Level premiums**
- **Long term benefits**
- **Premium discount to MSV members**
- **No group increases**
- **Pays for total and partial disability and/ or loss of income**
- **Liberal underwriting**

ENROLL IN YOUR NEW ASSOCIATION PLAN NOW!

For information call
John P. Pearl & Associates, Ltd.
(804) 282-9600 or 1-800-572-2211 or mail the coupon below

Please send me more information on the MSV endorsed Non-Cancellable Disability Program.

Name _____

Address _____

City _____ State _____ ZIP _____

Birthdate _____ Phone _____

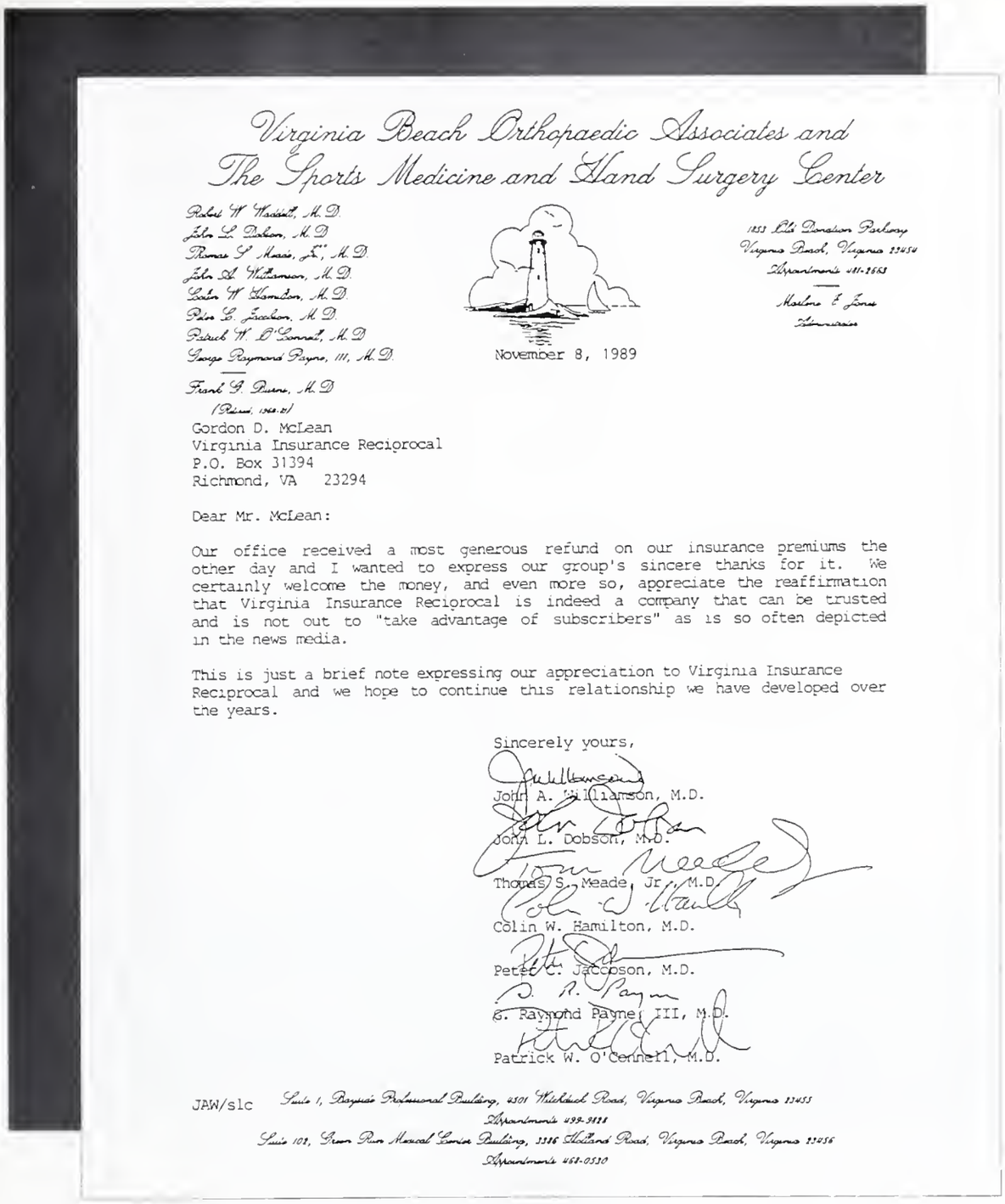
Best time to call _____

MSV/900230/3-90

Mail to:

John P. Pearl & Associates, Ltd.
6620 W. Broad St., Suite 300
Richmond, VA 23230-1724

Don't take our word for it...



Virginia Beach Orthopaedic Associates and
The Sports Medicine and Hand Surgery Center

Robert W. Waddell, M.D.
John L. Dobson, M.D.
Thomas S. Meade, Jr., M.D.
John A. Williamson, M.D.
Colin W. Hamilton, M.D.
Peter C. Jacobson, M.D.
Patrick W. O'Connell, M.D.
George Raymond Payne, III, M.D.

Frank G. Burns, M.D.
(Retired, 1968-81)

1853 Old Donation Parkway
Virginia Beach, Virginia 23454
Appointments 481-2663

Marlene E. Jones
Administrator

November 8, 1989

Gordon D. McLean
Virginia Insurance Reciprocal
P.O. Box 31394
Richmond, VA 23294

Dear Mr. McLean:

Our office received a most generous refund on our insurance premiums the other day and I wanted to express our group's sincere thanks for it. We certainly welcome the money, and even more so, appreciate the reaffirmation that Virginia Insurance Reciprocal is indeed a company that can be trusted and is not out to "take advantage of subscribers" as is so often depicted in the news media.

This is just a brief note expressing our appreciation to Virginia Insurance Reciprocal and we hope to continue this relationship we have developed over the years.

Sincerely yours,

John A. Williamson, M.D.

John L. Dobson, M.D.

Thomas S. Meade, Jr., M.D.

Colin W. Hamilton, M.D.

Peter C. Jacobson, M.D.

G. Raymond Payne, III, M.D.

Patrick W. O'Connell, M.D.

JAW/slc

Suite 1, Bayside Professional Building, 4501 Witchduck Road, Virginia Beach, Virginia 23455
Appointments 499-9828
Suite 102, Green Run Medical Center Building, 3386 Holland Road, Virginia Beach, Virginia 23456
Appointments 468-0530

[Unsolicited testimonial from one of the many thousands of physicians' groups which received an equity return distribution during 1989.]

Call us . . . we reciprocate.

The Virginia Insurance Reciprocal

4200 Innslake Drive
Glen Allen, Virginia 23060
Toll free: 1 800 284-TVIR—In Richmond: 747-8600

LETTERS

Another critic heard from

Dr. Bickers criticises VIRGINIA MEDICAL for being "dull, flat" and having "no wit."[1] I would go further and question the integrity of its editorial policies.

I was asked to review *Hidden Illness in the White House* by Crispell and Gomez for VIRGINIA MEDICAL. I submitted a 2,000-word review in which I said that it was an unscholarly work derived almost solely from secondary sources, some of which were misquoted; my review was deemed unacceptable. Subsequently a 700-word review of the book by a lawyer appeared in VIRGINIA MEDICAL.[2] I then wrote a letter to the Editor pointing out that the printed review was "confined to the legal aspects of presidential disability described in the last chapter of the book. The bulk of the book, which deals with the medical histories of Woodrow Wilson, Franklin D. Roosevelt, and John F. Kennedy, is ignored." I described the book as "a rewrite of already published material" and went on to say that "This near-plagiarism reaches its height in four illustrations copied from the Blairs' book, from which not only the pictures but also the captions are reproduced!" My letter was returned. The readers of VIRGINIA MEDICAL were therefore given a limited, even biased, description of the book.

As a former editor of a medical journal, I respect the right of an editor to reject any material submitted for publication. I cannot accept, however, what appears to be a deliberate circumvention of truthful, and verifiable, facts in favour of watered-down comments, presumably to avoid an unpleasant confrontation with a book's authors.

F. J. Spencer, MD, MPH

560 Caroline Drive
Ruther Glen, VA 22546

1. Bickers WM. Letters. Va Med 1990;117:6–7
2. Grad JD. Books. Va Med 1989;116:151

The Editor replies: Since book reviews are not scientific material, but rather opinion/point of view, the Editors reserve the right to approve such reviews before publication. Perhaps the journal of which Dr. Spencer is a former editor would publish his review.

Specialists in Handling Medical Waste

- HOSPITALS
- DENTAL
- LABS
- VETERINARY
- CLINICS
- PROPER STORAGE
- TRANSPORTATION
- DISPOSAL
- DOCUMENTATION
- CONSULTATION

CALL 1-800 MED-WAST

WMI Medical Services

The Medical Waste Solution.SM

1405 Gordon Avenue • Richmond, VA 23224

A Service of Waste Management

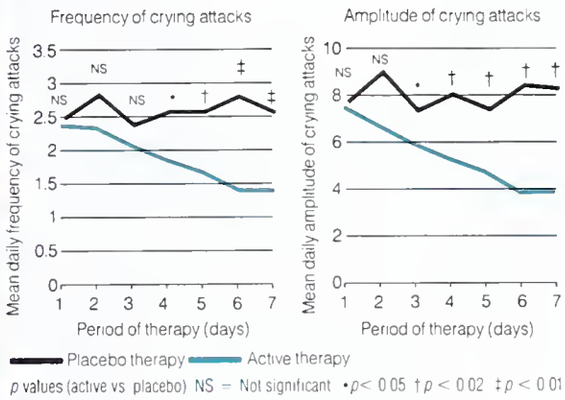
Family therapy for colic.

The excessive crying of colic puts a strain on the most loving family—and often on their physician as well. And whatever the cause of colic, one fact is clear:

Gas is often part of the colic problem.

New Phazyme Drops contains simethicone, which can safely break up gas and bring baby relief. That's why it can help whenever colic is a problem.

Significantly reduces crying of colicky infants.[1]



p values (active vs placebo) NS = Not significant •$p < 0.05$ †$p < 0.02$ ‡$p < 0.01$

Double-blind, randomized, placebo-controlled study

Priced 25% below the leading brand.

This significant price advantage will be particularly important to parents, since they may be relying on Phazyme Drops for up to three months. And it's naturally flavored—something else they'll appreciate.

NEW

Phazyme® Drops

(simethicone/antigas)

Helps you through the colic phase.

1. Kanwaljit SS, Jasbir KS. Simethicone in the management of infant colic. *Practitioner* 1988;232:508.

REED & CARNRICK
Piscataway, NJ 08855 ©1989 Reed & Carnrick PZ24

PUT YOUR MEDICAL CAREER IN FLIGHT.

Discover the thrill of flying, the end of office overhead and the enjoyment of a general practice as an Air Force flight surgeon. Talk to an Air Force medical program manager about the tremendous benefits of being an Air Force medical officer:

- Quality lifestyle, quality practice
- 30 days vacation with pay per year
- Support of skilled professionals
- Non-contributing retirement plan if qualified

Discover how to take flight as an Air Force flight surgeon. Talk to the Air Force medical team today. Call

USAF HEALTH PROFESSIONS

STATION-TO-STATION COLLECT 804-276-0459

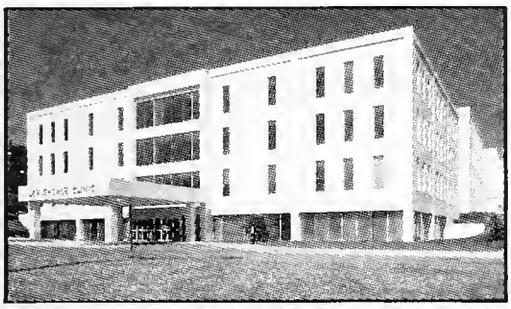
AIR FORCE

Lewis-Gale Clinic

Virginia's Largest Multi-Specialty Medical Group Practice

Full Medicare Participation

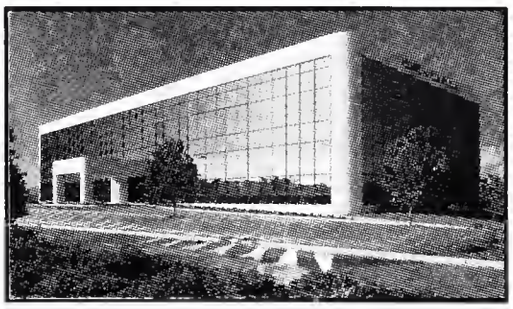
772-3400



1802 Braeburn Drive, Salem
Adjacent to Lewis-Gale Hospital
772-3400

Business Office
Medicare **772-3760**
All other accounts
(See top of Clinic
monthly statement)

Satellite Family Practice Clinics
BACK CREEK 989-0757
FINCASTLE 992-2110
FORT LEWIS 380-4300
NEW CASTLE 342-7677
WEST SALEM 387-0441



4910 Valley View Blvd., Roanoke
At Valley View Mall
265-1600

ALLERGY & IMMUNOLOGY
Paul F. White, M.D.

ANESTHESIOLOGY
Leigh O. Atkinson, M.D.
George P. Baron, M.D.
Daniel C. Summerlin, Jr., M.D.
Joe F. Clark, M.D.
George S. Coury, M.D.
Gennard T. Lanzara, M.D.

ARTHRITIS & RHEUMATOLOGY/ INTERNAL MEDICINE
William M. Blaylock, M.D.
Joseph P. Lemmer, M.D.

CARDIOLOGY
David S. Miller, II, M.D.
Jacob P. Neathawk, Jr., M.D.
J. Phillip Bushkar, M.D.
William B. Rutherford, Jr., M.D.

COUNSELING/PSYCHOLOGY
J. Steven Strosnider, LPC
Samuel B. Rogers, Jr., Ph.D.
Bruce A. Sellers, Psy.D.
John Heil, D.A.
Robert M. Lanahan, Psy.D

DERMATOLOGY
Gary P. Gross, M.D.
Larry W. Patton, M.D.

EMERGENCY MEDICINE
Benjamin N. Jones, M.D.
John S. Jeremiah, M.D.
John M. Garvin, M.D.
Robert O. McGuffin, M.D.
Thomas Gary Parrish, M.D.
Roger D. Tims, M.D.
Thomas M. Phillips, M.D.

EXECUTIVE HEALTH MEDICINE
Lucian Y. Grove, Jr., M.D.

FAMILY PRACTICE
Allen M. Clague, M.D.
Keith C. Edmunds, M.D.
William C. Crow, Jr., M.D.
Samuel N. Smith, M.D.
Howard W. Lebow, M.D.
Wilson H. Coulter, M.D.
John F. Daugherty, M.D.
Clarke B. Andrews, M.D.
Marc G. Nevin, M.D.
Ella M. Dickinson, M.D.
Kevin C. Kelleher, M.D.
David A. Keilman, M.D.
Gregory L. Still, M.D.
James W. Robinson, M.D.
Charles E. Lamb, M.D.
Clement B. Binnings, Jr., M.D.
William C. Greer, M.D.
Victor H. Bell, M.D.

FERTILITY & REPRODUCTIVE HEALTH
James Freeman Holman, M.D.

GASTROENTEROLOGY & ENDOSCOPY/ INTERNAL MEDICINE
George H. Wall, M.D.
Joseph L. Nelson, III, M.D.
M. Jonathan Bern, M.D.
Douglas W. Kirtley, M.D.

HEMATOLOGY & ONCOLOGY/ INTERNAL MEDICINE
Paul D. Richards, M.D.
William A. Fintel, M.D.

INFECTIOUS DISEASE/ INTERNAL MEDICINE
Douglas D. Blevins, M.D.

INTERNAL MEDICINE
Michael J. Moore, M.D.
E. Blackford Noland, Jr., M.D.
Myron S. Levey, M.D.

INTERNAL MEDICINE
Daniel M. Camden, M.D.
Lucian Y. Grove, Jr., M.D.
Linda S. Brunson, M.D.

NEUROLOGY/ NEURO-OPHTHALMOLOGY
Edward A. Waybright, M.D.
Timothy L. Hormel, M.D.
Gary J. Harpold, M.D.

NEUROSURGERY
Charles H. Anderson, Jr., M.D.

OBSTETRICS & GYNECOLOGY
Carl B. Harms, M.D.
James A. Kelly, M.D.
George W. Maxymiv, M.D.
Debra H. Clapp, M.D.
Mark W. Gustafson, M.D.

OCCUPATIONAL MEDICINE
E. Wilson Watts, Jr., M.D.
Darrell F. Powledge, M.D.
Benjamin N. Jones, M.D.

OPHTHALMOLOGY
J. Stanwood Till, M.D.
Donna L. Maxfield, M.D.

ORTHOPAEDIC SURGERY, HAND SURGERY AND SPORTS MEDICINE
Richard H. Fisher, M.D.
Alonzo H. Myers, Jr., M.D.
S. Curtiss Mull, M.D.
Bertram Spetzler, M.D.
John P. Clarke, M.D.
Brian A. Torre, M.D.
James W. McLeod, M.D.

OTOLARYNGOLOGY
J. Bruce Hagadorn, M.D.
Tu A. Tran, M.D.

PATHOLOGY
Anthony V. Torre, M.D.

PEDIATRICS
F. Joseph Duckwall, M.D.
William J. Kagey, M.D.
Luthur A. Beazley, III, M.D.
Dawn Elizabeth Forbes, M.D.
Lee Anne Steffe, M.D.

PLASTIC RECONSTRUCTIVE & HAND SURGERY
Robert F. Roth, M.D.
Carol A. Reichel, M.D.

PULMONARY DISEASES/ INTERNAL MEDICINE
James A. Witten, Jr., M.D.
Nelson B. Greene, M.D.

RADIOLOGY & NUCLEAR MEDICINE
Clyde F. Lloyd, M.D.
William A. Cassada, Jr., M.D.
J. William Barnard, M.D.
John M. Mathis, M.D.
Mary Ella Zelenik, M.D.
Placido H. DeGuzman, M.D.
Bruce C. Banning, Jr., M.D.

GENERAL THORACIC & VASCULAR SURGERY
William L. Sibley, III, M.D.
George R. Shumate, M.D.
A. Reif Kessler, M.D.

UROLOGY
T.S.R. Ward, M.D.
Jeffrey S. Jones, M.D.

Accredited by the
Accreditation Association
for Ambulatory Health Care

NEW MSV MEMBERS

Albemarle County Medical Society

Michael D. Dickens, MD, Pediatrics, 103 Kerry Lane, Charlottesville VA 22901

Dan Lawson, MD, Anesthesiology, Box 238, University of Virginia Health Sciences Center, Charlottesville VA 22908

David B. Mika, MD, Psychiatry, 3025 Berkmar Drive, Charlottesville VA 22901

Robert J. Roberts, MD, Pediatrics, University of Virginia Health Sciences Center, Charlottesville VA 22908

John B. Selby, Jr., MD, Radiology, Box 170, University of Virginia Health Sciences Center, Charlottesville VA 22908

Alexandria Medical Society

Albert A. Herrera, MD, Internal Medicine, 8101 Hinson Farm Road, Alexandria VA 22306

Alleghany-Bath Counties Medical Society

James F. Redington, MD, Family Practice, PO Drawer 797, Hot Springs VA 24445

Bedford County Medical Society

Samir G. Ghobrial, MD, Obstetrics/Gynecology, 1700-B Whitfield Drive, Bedford VA 24523

Culpeper County Medical Society

Mark B. Gloudeman, MD, General Surgery, 633 Sunset Lane, Culpeper VA 22701

Danville-Pittsylvania Academy of Medicine

Daniel L. Pomposini, MD, Internal Medicine, 101 Holbrook Street, Danville VA 24541

Fairfax County Medical Society

Raul E. Armengol, MD, Emergency Medicine, 6117 Beachway Drive, Falls Church VA 22041

Valerie J. Buyse, MD, Psychiatry, 6310 Kellogg Drive, McLean VA 22101

Thomas J. Neviaser, MD, Orthopedic Surgery, 3650 Joseph Siewick Drive, Fairfax VA 22033

Mohsen Ziai, MD, Pediatrics, 3300 Gallows Road, Falls Church VA 22046

Fauquier Medical Society

Margaret N. Jeffries, MD, Pediatrics, Route 2, Box 406 A-2, Amissville VA 22002

Halifax County Medical Society

Charles W. Rosche, MD, Obstetrics/Gynecology, 2212 Halifax Road, South Boston VA 24592

Lynchburg Academy of Medicine

Finnie Green, MD, Urology, 1915 Thomson Drive, Lynchburg VA 24503

DO NEW MEDICAL MALPRACTICE CARRIERS MAKE YOU NERVOUS?

Some medical malpractice carriers offer a low price the first couple of years. After that, who knows?

We've been independent brokers for more than forty years and can offer competitive policies and premiums. We're not limited to an endorsed policy or exclusives required by many insurance carriers.

Find out about some **"A+"** companies who have established a track record. Save yourself some money.

We can advise you on the *best* policy for all your needs—from the *best* company at the *best* price. Frankly, we can handle all your professional and personal insurance needs, from office packages to auto coverages.

Call Clements and Company today for an "independent's approach" to buying medical malpractice insurance.

INSURANCE BROKERS WORLDWIDE

CLEMENTS AND COMPANY

Specialist in Medical Malpractice Insurance

Telephone: (202)872-0060 **Fax:** (202)466-9064

Telex: 64514 **Cable:** CLEMENTS/WASHINGTON

1730 K Street, NW, Suite 701, Washington, DC 20006

Norfolk Academy of Medicine

Regina G. Lemly-Mundy, MD, Internal Medicine, 825 Fairfax Avenue, Norfolk VA 23507

Noel Parent III, MD, General Surgery, 250 West Brambleton Avenue, Norfolk VA 23510

Carolyn M. Riegle, MD, Pediatrics, 330 West Brambleton Avenue, Norfolk VA 23510

Northern Neck Medical Society

Harold H. Weiler, MD, Ophthalmology, Route 1 Box 580, Weems VA 22576

Northern Virginia Medical Society

David K. Harry, MD, Diagnostic Radiology, 3577 Brookneill Drive, Winchester VA 22601

Audrea H. Wynn II, MD, Orthopedics, 128 Medical Circle, Winchester VA 22601

Patrick Henry Medical Society

Elizabeth R. Vaughan, MD, Emergency Medicine, One Country Club Road, Bassett VA 24055

Portsmouth Academy of Medicine

Robert J. Accettola, MD, Cardiology, 4041 Taylor Road, Chesapeake VA 23321

Richmond Academy of Medicine

Richard L. Gergoudis, MD, Family Practice, 3540 Floyd Avenue, Richmond VA 23221

Roanoke Valley Academy of Medicine

John C. Conrad, MD, Anesthesiology, PO Box 13306, Roanoke VA 24032

Mark O. Smith, MD, General Surgery, 4235 Colonial Avenue SW, Roanoke VA 24018

Rockbridge County Medical Society

Malcolm L. Cothran Jr., MD, Internal Medicine, 110 Houston Street, Lexington VA 24450

Southside Virginia Medical Society

Bruce A. Miller, MD, Family Practice, 815 West Poythress Street, Hopewell VA 23860

Southwestern Virginia Medical Society

Bertram J. Newmark, MD, Diagnostic Radiology, PO Box 116, Blacksburg VA 24063

Orren L. Royal, MD, Psychiatry, Route 1, Box 203, Dublin VA 24084

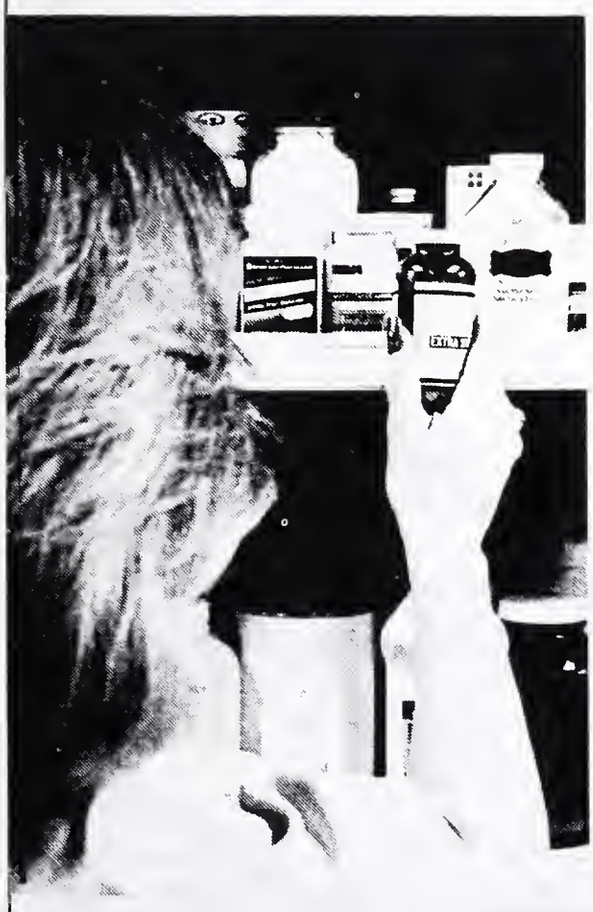
Tri-County Medical Society

Moussa Y. Menasha, MD, Gastroenterology, 819 General Pickett Drive, Suffolk VA 23434

Michael Ponder, MD, Family Practice, 812 Clay Street, Franklin VA 23851

Virginia Beach Medical Society

Michael Graham, MD, Orthopedic Surgery, 1016 First Colonial Road, Virginia Beach VA 23454



HEADACHE

THERE IS AN ALTERNATIVE

Headache is the most common disorder of modern man. It has been estimated that one out of three Americans suffers from severe headaches at one time or another.

The RICHMOND HEADACHE CENTER is a unique facility which specializes in the diagnosis and management of chronic and recurrent headaches.

The RICHMOND HEADACHE CENTER was founded by a group of practicing neurologists and clinical psychologists who recognized the need for a cooperative effort in treating chronic and recurrent headaches.

For more information, write or call .....

YES, please send me more information about RICHMOND HEADACHE CENTER.

NAME

ADDRESS

STATE

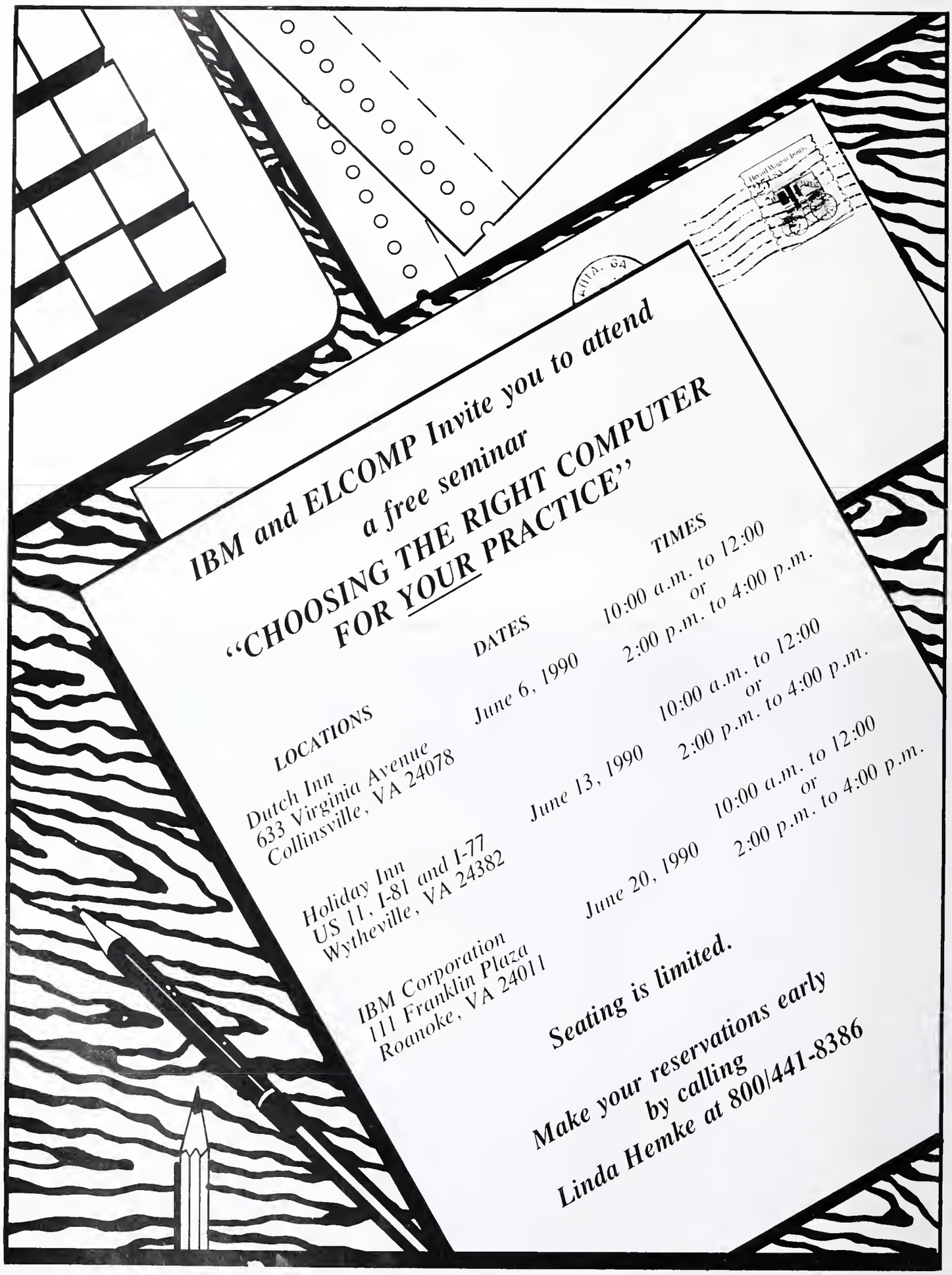
ZIP CODE PHONE

MAIL TO: RICHMOND HEADACHE CENTER
909 Hioaks Road, Suite I
Richmond, Virginia 23225

RICHMOND HEADACHE CENTER

909 Hioaks Road, Suite I
Richmond, Virginia 23225
Telephone (804) 320-3750

ELCOMP® systems, inc.



MEETINGS

June 4-8
6th Edition, Family Medicine Review Course (Eastern Virginia Medical School), *Virginia Beach*. CME Office, 804-446-6140.

June 4-8
General Surgery Seminar: Update and Review (Lloyd Noland Hospital), *Hilton Head Island, South Carolina*. CME Office, 205-783-5276.

June 6-10
7th Annual Meeting of the Southern Orthopaedic Association, *Maui, Hawaii*. Kathy McLendon, 205-945-1848.

June 7-9
Update in Obstetrics (American College of Obstetricians/Gynecologists), *Norfolk*. 16 credit hrs. Fee, $515. ACOG Registrar, 800-673-8444.

June 7-10
14th Annual Postgraduate Course on Rehabilitation of the Brain-Injured Adult and Child (Medical College of Virginia/VCU), *Williamsburg*. CME Office, 804-786-7290.

June 11-15
Adult Infectious Disease Seminar: Current Update (Lloyd Noland Hospital), *Hilton Head Island, South Carolina*. CME Office, 205-783-5276.

June 14-16
35th Annual Great Smokey Mountains Pediatric Seminar (University of Tennessee), *Gatlinburg, Tennessee*. Abby Hall, 615-544-9190.

June 15-16
Arrhythmnias: Interpretation, Diagnosis and Management (Medical Education Resources), *Williamsburg*. Deborah Helton, 800-421-3756.

June 20-23
Second Baltimore Perinatal Colloquium (Johns Hopkins/University of Maryland), *Baltimore*. 24 credit hrs. Office of CME, 301-955-2959.

June 21-24
Annual Meeting, Virginia Society of Ophthalmology, *Norfolk*. Donna Scott, 804-353-2721.

June 22-24
Clinical Pediatrics (American College of Pediatrics), *Washington, DC*. 16 credit hrs. CME Registration, 800-421-0589.

June 24-27
17th Annual Harvard Medical School Course on Interstate Care Medicine: The Art and Science of Critical Care, *Boston Massachusetts*. Bart Chernow, MD, 617-726-2858.

June 26-30
Family Practice Seminar: Update and Review (Lloyd Noland Hospital), *Hilton Head Island, South Carolina*. CME Office, 205-783-5276.

July 16-20
Control of Biohazards in the Research Laboratory (Johns Hopkins), *Baltimore*. Byron S. Tepper, PhD, 301-955-5918, or Dr. Jacqueline Corn, 301-955-2609.

July 20-22
Practical Internal Medicine (Medical College of Virginia/VCU), *Virginia Beach*. CME Office, 804-786-0494.

July 26-29
40th Annual Scientific Assembly of the Virginia Academy of Family Physicians, Cavalier Hotel, *Virginia Beach*. 21½ credit hrs. VAFP headquarters, 804-358-1721.

July 27-29
12th Annual Pediatric Primary Care Conference: Pediatrics at the Beach (Medical College of Virginia/VCU), *Virginia Beach*. CME office, 804-786-0494.

September 8
Regular meeting of the Medical Society of Virginia's Council, *Richmond*. James L. Moore, Jr., 804-353-2721.

The George Washington University Center for Vascular Disease Presents . . .

UPDATE ON PERIPHERAL VASCULAR DISEASE AND RISK FACTOR INTERVENTION FOR THE PRIMARY CARE PHYSICIAN

to be held at Ross Hall, 2300 Eye Street, NW, Washington, DC

June 7—June 8, 1990

The George Washington University Medical Center ■ Washington, DC

For more information, contact The George Washington University Medical Center's Office of CME, (202) 994-4285.

VIRGINIA
MEDICAL
MAY 1990

How to Sell a Solo Practice

Planning for the sale of a practice should begin two years before you intend to leave, say the authors. They offer guidelines to setting a price and on negotiating that price with a prospective buyer.

A physician who has put blood, sweat and tears into a practice expects some return when finally the decision is made to sell it. To receive that full value, however, there needs to be careful planning and preparation. Realistically, you wouldn't expect to buy a new home without getting the facts; don't expect someone to buy your practice without knowing all the important details as well. Much the same as in selling a house, selling a practice takes time. Expect to spend at least six months to one year searching for the appropriate buyer, negotiating the terms and finalizing the deal. And also don't forget the transition period, for the most crucial step of a practice transfer is the period in which the buyer and seller work together and cement their relationship. This period can easily extend to three or four months.

Planning is essential, and our general advice is to begin at least two years before you want to leave your practice. Chiefly, your planning must deal with the following three questions.

Do you have something to sell? Take a good hard look at your practice. Is the gross revenue healthy? Hopefully, your income hasn't dropped and your work levels in past years are consistent. How is the location? Would someone want to spend most of their time where you are currently practicing? If the demographics of the neighborhood have changed since you first hung out your shingle, incorporate that into your thinking.

How is the competition? Moderate competition is a good thing; no competition usually means there is no reason to buy. Why? Either the area is considered less than desirable and is underserved, or the population can't support another practitioner. In the first scenario, a candidate could set up down the street and have a healthy income without buying; in the second, why would he buy when you're leaving anyway? If your area needs only one physician and you're going, the candidate can wait until you're gone, and set up shop.

Keep your plans to yourself and your advisors. The biggest mistake you can make is to let your best friend (who's also your best referral) know that you are moving to Florida as soon as you sell the practice or by

---

This text was excerpted from a series of articles developed by The Health Care Group, a practice management consulting firm © 1990. The principal authors were Mark E. Kropiewnicki, JD, LLM, and Dorothy R. Sweeney of The Health Care Group, Meetinghouse Business Center, 140 West Germantown Pike, Suite 200, Plymouth Meeting PA 19462.

January 1, whichever comes first. The word *does* get out and all of your potential buyers will either vanish until December 15 or try and push the price down. When you are interviewing prospective candidates, be honest and straight-forward about anything they'll need to know, but they don't need to know how anxious you are to start your retirement!

How much? If you want an objective view of what your practice is worth, have it appraised. Besides analyzing your location, competition and your revenue and expenses, a good appraisal will give you an idea of what the market can handle. Unfortunately, there is no magic formula you can apply to come up with the "right" selling price. In fact, there are many valuation techniques, and depending on what journal you're reading or which accountant you're talking to, there are a dozen "standard" methods to value a medical practice. No single method has proven to be correct or accepted in all cases. The "real" value will be determined when the deal is signed. And it is usually one area where everyone has an opinion.

However, the dollar figure given by an appraiser is a good starting point. Be sure that whoever puts a value on your practice has previous experience with medical practice sales; don't rely on the accountant or attorney who is taking this on as a "new" project.

Of all the methods that are currently being used, the Gross Revenue Multiplier is the most widely quoted. The multiplier is the ratio of practice value to annual revenues. In other words, a practice with a price tag of $100,000 and a gross revenue of $200,000 is selling at 50% of gross revenue. While the multiplier is helpful in establishing a benchmark in which to start negotiations, every practice has different characteristics, which will affect its value. Just because Dr. Smith's practice across town with the same specialty as yours sold for 60% of his average gross, doesn't mean that is your magic number too. When a practice comes to market, each buyer and seller will rely on the multiplier as a starting point. But, since the multiplier represents an average of practices evaluated, it should not be quoted as the ultimate authority.

Many sellers (regardless of specialty, years in existence, location or profitability) tell us they expect to receive one year's gross income for the sale of their practice. It just isn't so! Rarely do we ever hear of a practice selling for a number that high. Primary care practices that can offer the benefits of referrals to their neighborhood hospitals will sometimes approach that number, but more times than not that number was quoted by an advisor who wasn't aware of what the market will bear for medical practice sales.

Sellers who insist on starting their negotiations at such a high level will soon find potential buyers are scared away. The best way to justify your selling price is to find evidence of it happening before. But remember, each practice is unique and requires individual analysis for determination of fair market value. Know the market before you begin, and recognize that each person in a buy-sell transaction may feel a little dissatisfied when the deal is finished—but it is certainly better than no deal at all.

Goodwill

In most practice sales, the goodwill factor is not readily isolated. A sale typically is negotiated for the practice as a whole, not for its component parts.

Subject to numerous variables applicable to each particular circumstance, the following are our updated goodwill guidelines.

Primary Care. These practices (family practice, general practice, pediatrics, and office-based primary care internal medicine, for example) still sell at around 50% of annual gross income, though we see a slight upward trend. In a negotiating situation, we might now suggest asking for 60% (or even slightly more), hoping to sell at a bit over 50%.

Referral Practices. Because both general and specialty surgeons rely largely on physician referrals for most of their work, as do subspecialty internists like cardiologists and G.I. doctors, their practice goodwill values are less. Our guideline is 20% to 30% of annual gross income although some may be in the mid-30s.

Ophthalmology. Because it combines the ongoing patient volume of a primary care practice with the likelihood of surgery for some of those patients, ophthalmology is still probably the most "valuable" specialty of them all; however, we are concerned that continued fee pressures will further depress the goodwill figure. By the very nature of its practice mix, ophthalmology should have a greater economic value than primary care. There is still an active market in the sale of ophthalmology practices, partly because many doctors believe that "market share" of patients will be vital if reimbursements fall further.

Ob/Gyn. The value of this specialty is puzzling, and we estimate it at 30% to 40% of gross annual receipts. The scarcity of these specialists, due to the malpractice climate and the tough on-call demands, makes a practice sale far more doubtful than in other specialties.

Dermatology, Allergy, Neurology. These internal medicine-related practices have many economic characteristics similar to those of primary care. Dermatology is holding up to a 50% of gross guideline, but allergy seems to be slipping. An allergist may ask 50%, but should be prepared to settle for less, especially if the practice lacks a very strong patient base. Neurologists are somewhat above subspecialty internists as to goodwill value, so our guideline range is 35% to 50% of annual receipts.

RAP. The hospital-based practices, like radiology, anesthesiology, and pathology, have no pattern. Their values depend too much on hospital contracts, so that there is often no true sale likelihood at all. We assume no more than a minimal, 10% of gross valuation, merely to

recognize the practice as a going concern.

Tax Considerations

A significant factor to consider in arriving at the sales price will be how the sales transaction will affect income taxes of both the buyer and seller.

1. Equipment and Furnishings. From the buyer's tax standpoint, the highest possible allocation to practice equipment and furnishings is desirable. The buyer benefits from an election to immediately deduct as an expense up to $10,000 of the hard assets' cost and from depreciation deductions, usually over five or seven years. The buyer thus can write off the purchase price of hard assets and thereby reduce their after-tax cost.

The seller will usually have less favorable tax benefits on hard assets. While some of the price may be nontaxable, as return on undepreciated original cost, most of the purchase price will probably be taxed as ordinary income—to the extent of depreciation taken in prior years. If the seller has not owned an item generally for at least five years, he/she would have to repay part of all of any investment tax credit previously taken on those assets.

2. Goodwill. Any amount paid for good will cannot be depreciated or deducted at all. Thus, the buyer will negotiate hard to keep the contract amount attributable to goodwill at a minimum.

If the seller did not purchase the practice from another physician, his/her tax basis in goodwill is zero. Thus, the entire amount attributable to goodwill will be taxed at the maximum income tax rate.

3. Accounts Receivable. Practice sales generally do not include accounts receivable. Buyers usually do not wish to pay for amounts that may or may not be collected from patients or third-party payers. In addition, Medicare and Medicaid rules prohibit the sale or assignment of

continued on page 199

Who's Who:

Dr. John A. Murray of Franklin has retired, thus winding up 36 years of pediatrics and 14 years on the City Council, two years as Franklin's mayor, and a term as president of the Franklin/Southampton Chamber of Commerce. Dropping out of such a productive life will be a big change, and he wasn't sure he was going to like it when he was interviewed by Jim Hekel of the *Tidewater News*. "The kids," that's what he'll miss most, he said. "I've always enjoyed the kids. They are refreshing and invigorating, simply amazing."

Dr. Murray was born in Richwood, West Virginia, where his father was a pharmacist. In the Navy, during World War II, he had a taste of medicine as a medical corpsman and, when he returned from the service, he taught school while waiting for admission to medical school. He graduated in 1952 from the Medical College of Virginia and the next year, after canvassing the state for possible practice locations, settled in Franklin.

City politics were a magnet for Dr. Murray. "I'm interested in the operations of the community, especially the schools," he told the reporter. "During my time on council we established the city's first industrial park, built new schools, and set a limit of two terms as a maximum anyone can serve on the School Board. I would like to see the two-term standard imposed on all public offices, from US Senator on down."

Dr. Murray and his wife Margaret have four children, all now grown and scattered to Richmond, California, DC, and New York.

For her "indelible mark on Warren County of a lifetime of service to her community," **Dr. Elizabeth B. Sherman** was named Citizen of the Year by the *Front Royal News* late last year. Earlier, the 90-year-old physician had retired (Va Med March 1989), telling a reporter for the *News*, "I'm tired, if you want to know the truth."

Graduated at the top of her class from the University of Maryland Baltimore County Medical School in 1926, Dr. Sherman trained for general practice, including a residency in pediatrics in New York City, before opening her office in Front Royal in 1934. She was instrumental in organizing efforts to build Warren Memorial Hospital and is now on that hospital's emeritus medical staff.

After practicing dermatology in Danville together for more than 30 years, **Drs. Eugene M. Evans, Jr.**, and **Walter C. Fitzgerald** closed their office last year and retired together.

Dr. Fitzgerald, a graduate of the University of Virginia School of Medicine (1943), was the only dermatologist in the county when he began the practice in 1953. Four years later he met Dr. Evans at Duke University, where Evans was finishing his medical studies and Fitzgerald was doing some consulting, and the two turned the practice into a partnership.

The first item on Dr. Fitzgerald's retirement agenda is to make Buggs Island his permanent home, not only for its waterside attractions but because it's a great place for runners. Dr. Fitzgerald began running 30 years ago and at 70 is a marathon class competitor who was the winner in his age division in a recent Richmond Marathon.

Dr. Evans intends to travel, travel, travel. He recently completed a 5,400-mile motor trip through the West and now is looking toward "a whole world out there I want to see," he told a reporter for the Danville *Bee*, especially the Pacific Is-

Retirements

lands, Australia, and Japan.

It took three years, the dermatologists recalled, to find a doctor to take over the pair's practice. He is **Dr. Michael C. White**, who was graduated from the Medical College of Virginia/VCU in 1981 and used to call Norfolk his home.

A medical career spanning both private practice and public health ended last year when **Dr. John M. Stirewalt** of Waynesboro retired from Western State Hospital. He had served his entire professionalcareer in Augusta County and was at Western State for 22 years.

Both in New Market, Virginia, Dr. Stirewalt was graduated from both the University of Virginia and its School of Medicine (Class of 1951) and trained in ENT at the university's hospital. He first entered public health as medical director for Woodrow Wilson Rehabilitation Center, Fishersville, then changed to a private practice in Waynesboro, returning to public health as assistant director for the Augusta/Staunton Health District. At Western State, which he joined in 1966, Dr. Stirewalt filled both clinical and administrative posts, including chief of staff of the medical center.

Throughout his career, Waynesboro has been home base for Dr. Stirewalt and his wife, the former Virginia Dean. They have four children and four grandchildren.

After 31 years of practice in Alleghany County, **Dr. Alvin W. Finestone** has retired from the radiology department of Alleghany Regional Hospital, Low Moor. He had been at Alleghany Regional since it opened ten years ago; before that he was at the Chesapeake & Ohio Hospital (now Emmett Memorial) in Clifton Forge.

Born in Philadelphia, Dr. Finestone earned his MD in medicine in his hometown at Temple University's School of Medicine, then trained at hospitals in New Jersey, New York, and Pennsylvania. Looking for a practice site after completing a tour of duty with the Army, Dr. Finestone answered an ad in *JAMA* seeking a small-town radiologist and soon was on his way with wife Elaine to Clifton Forge. He joined **Dr. George N. Chucker**, now also retired, at Chesapeake & Ohio, and they were that hospital's entire radiology department from 1958-1970.

Dr. and Mrs. Finestone have reared three children; one of them, **Douglas H. Finestone, MD**, followed his father into medicine and is now practicing psychiatry in Greenville, North Carolina. His father has not given up radiology entirely; to keep his hand in, as he puts it, he is working 10-12 weeks a year for Comp Health, a national firm which he represents at exhibits around the country.

As for his erstwhile associate, Dr. Chucker, who retired in 1986, he was notified recently that he has been elected a fellow emeritus of the American College of Radiology. A past president of the Virginia Chapter, ACR, Dr. Chucker was for six years a member of the national organization's Board of Councilors.

In Urbanna, **Dr. Arthur L. Van Name, Jr.**, Medical College of Virginia '36, past president of the Mid-Tidewater Medical Society, and present member of the State Board of Medicine, has retired after 40 years of general practice, but he doesn't want anything said about it, so we won't.

When **Dr. Jorge A. Naranjo** of Boykins retired late last year after 25 years of family practice, Mayor Rick Francis signed a proclamation honoring him as a "selfless, caring humanitarian" and declared Sunday, October 8, as Jorge A. Naranjo Appreciation Day. The community followed up with a public celebration of the Day at the Boykins firehouse.

A native of Ecuador, Dr. Naranjo came to the United States to study medicine, and, after a residency at Louise Obici Memorial Hospital in Suffolk, established his private practice in Boykins in 1964.

In Culpeper, the community's first full-time surgeon is retiring after nearly 30 years of practice at Culpeper Memorial Hospital. He is **Dr. Grahame F.T.W. Henson**, a Welchman who came to the States after practice in a London hospital during the air raids of World War II and stints with the British Army in India and British Somalia. He was on the junior attending staff at the University of Virginia when Culpeper Memorial opened its doors and asked him to come on in as its first surgeon. He started on July 4, 1960, and early on did orthopedic, gynecologic and ENT procedures, though that agenda contracted as the specialties came along. He has been a trustee on both hospital and parent board and has twice served as president of the CMH medical staff.

To mark Dr. Henson's retirement, the hospital sponsored a dinner and "roast" in his honor @ $25 a head and designated the proceeds to the Windmore Foundation, a local art and drama organization in which the surgeon is much interested. Dramatics have long been an enthusiasm of his, perhaps, he suggested to Kathleen Hoffman of the *Culpeper News*, because "surgery and the theater

Who's Who:

have flamboyance in common." While in Africa in the forties he acted with the Nairobi Repertory Company; he headed up Culpeper's bicentennial pageant ("a big hit," according to the review); and he has usually done a star turn in the Pink Ladies' Follies, the annual hospital auxiliary benefit. He has no intention of retiring from his activities behind the footlights and in the wings, and he hopes as well to write two books, one about medicine with an autobiographical basis and the other probably a "murder thing with a hospital setting."

He was the first full-time anesthesiologist in Waynesboro. Now, after nearly 30 years of "passing the gas" at Waynesboro Community Hospital, **Dr. John P. Heatwole** has retired. But only from anesthesiology, he emphasizes. He'll go right on with a heavy schedule of projects as woodworker, church volunteer, photographer, computer buff, and writer. "I'm hoping to publish a genealogy newsletter," he told reporter Louis Andrews of the Waynesboro *News-Virginian* as he showed him a copy of "David Heatwole and His Descendants," a family history of his authorship.

After graduating in '54 from the Medical College of Virginia, Dr. Heatwole started out as a family physician in Harrisonburg, but he became interested in anesthesia and got his training for it in the Navy. In 1960 he and his wife Anita, a registered nurse, settled in Waynesboro; there they have reared two daughters and a son, all now grown. The son, **Dr. Kenneth M. Heatwole**, followed his father into medicine, graduating from MCV in 1984, and now is a pulmonary specialist at the University of Virginia Health Sciences Center in Charlottesville.

Two GPs who retired recently after long service in South Hill were honored when the Community Memorial Healthcenter gave its 1989 board of trustees/medical staff Christmas party. In the spotlight were **Dr. Thomas A. Saunders**, 39 years of service, and **Dr. Z. Dean Sadighian**, 21 years.

Dr. Charles H. Crowder, Jr., and **Dr. Wallace J. Horne** spoke in tribute to their colleague, Dr. Sadighian, who was unable to be at the ceremony. Dr. Saunders was on hand, however, to hear **Dr. F.C. Sturmer** read the resolution in praise and hand him a framed copy of it.

Each year the Women's Auxiliary of the Northampton-Accomack Memorial Hospital selects as honorary chairman of its Charity Ball a person whom it wishes to recognize for contributions to the Eastern Shore and its hospital. The most recent recipient of this honor is **Dr. E. Milton Kellam** of Belle Haven, whose selection happened to occur shortly after his retirement from surgery after almost 40 years of practice.

Born on the Eastern Shore in Belle Haven in the house where he still lives, Dr. Kellam is the son of the late **Dr. Sydney S. Kellam**, a family doctor who practiced out of his home until his death in 1933. The son went to Hampden-Sydney, then the University of Virginia School of Medicine (Class of '43), then completed his training in New Britain, Connecticut, first in pathology, then in surgery. He returned to the Eastern Shore in 1951 and went into partnership with three other surgeons. At the time the four were the only surgeons on the Eastern Shore; today there are 11 surgeons, many of them specialists.

In 1954 Dr. Kellam met and married a young woman named Joan Lansford who was working in th hospital record room; they hav three children, all now grown.

No sooner had **Dr. James I Chapman**, Falls Church, retire from private practice and the med cal directorship of Dominion Hosp tal than he picked up an appointmer to the board of governors of th Northern Virginia Institute for Co tinuing Medical Education. The i ternist also will continue as medic advisor at a high-tech firm involve in developing an eye-operated con puter system for severely disable persons. Dr. Chapman is a graduat of George Washington Universit School of Medicine, Class of '49.

For 45 years **Dr. A. W. Graves** saw patients in the big white hous in Lacey Spring where his father ha long practiced medicine. Then, i 1985, the general practitioner dis covered he had Parkinson's disease and that spelled retirement. He' coping nicely, according to Jim Har key of the Harrisonburg *News Record*, thanks to the help of hi wife Ida, who was trained as a nurse and two sons, Owen and A.W. Vi who take turns driving from Harri sonburg to Lacey Spring to accom pany their father when he drives car. Dr. Graves is a graduate of th University of Virginia School o Medicine, Class of '39, and traine at Norfolk General.

Way back in June 1989, Va Me reported that **Dr. E. M. Henderso** had closed his office in Nassawado on the Eastern Shore. To the Edi tors' regret, the report was mislead ing. True, Dr. Henderson resigne from the professional partnershi with which he had been associated but he continues in general practice albeit, he says, "in a limited way."

Retirements

After six decades of service to the people of Halifax County, the doors of Little Retreat Clinic in Clover were closed last September and **Dr. William J. Hagood, Jr.**, said good-bye to the patients. He had done his best to find a physician to join him in the clinic after the cousin with whom he had shared the clinic for 35 years, **Dr. Warren C. Hagood**, retired earlier in the year, but though several prospects had taken a look, none had signed on, and at 72, "Dr. Bill" Hagood couldn't go it alone.

Dr. Bill's uncle, **Dr. James D. Hagood**, pulled his nephew into the clinic in 1946 when the younger doctor got out of the Army. Dr. Jim had bought the clinic building in the early twenties from **Dr. Rawley A. Fuller**, who used it as a hospital for his surgical practice. (Dr. Fuller then moved ten miles southwest to South Boston and founded a hospital that eventually became Halifax-South Boston Community Hospital, where a son, **Dr. W. Allen Fuller**, now practices surgery.)

In 1954 Dr. Warren joined the two, and during the following years the three doctors treated 30-45 patients a day.

Thanks to the untiring clinical support of his two associates, Dr. Jim Hagood could take the time to serve in the Virginia State Senate for 29 years (1942-1971) and in the fifties was President of the Medical Society of Virginia. He died in 1972.

Dr. Bill Hagood was MSV President, too, in 1978-79, and is currently an MSV delegate to the American Medical Association.

Five retired physicians who made significant contributions to medical service in Smyth County were recognized recently by the medical staff of Smyth County Community Hospital in Marion. They are **Dr. Charles G. Thompson, Dr. E. V. Richardson, Sr., Dr. C. C. Hatfield, Dr. Joseph J. Eller**, and **Dr. J. Stuart Staley**. They were presented with plaques signifying their election to honorary membership on the hospital's medical staff, the first time such recognition has been accorded. □

Dr. Bill Hagood at the Little Retreat Clinic in 1949.

accounts receivable of Medicare and Medicaid patients.

However, for those occasions where accounts receivable are sold, that sum must be reported as ordinary income by the selling physician. The buying physician is not taxed on collection of such purchased receivables to the extent of their purchase price. A tax deduction is allowed if the buyer collects less than was paid for the accounts receivable. If more is collected on the accounts receivable than was paid for them, such excess is taxable to the buyer as ordinary income.

If accounts receivable are not sold with the practice, both parties will typically find it valuable for the purchaser to bill and collect receivables for the selling physician. Thus, practice continuity is established in patients' minds and is of benefit to the purchasing physician. In this way, the selling physician has a better chance of collecting his or her receivables and need not maintain a staff or billing system.

4. Leasehold Improvements. If there are leasehold improvements sold with the practice, the buyer will be able to depreciate the cost of those improvements on his or her tax return. Tax rules now generally require such improvements to be tax-deducted over a rather long time. The selling doctor will be taxed on any gain over the cost of those improvements.

5. Office and Equipment Leases. Occasionally, the buyer will pay the seller a premium to assume a favorable current office lease or to assume the lease on equipment that the practice rents. The amount realized by the seller is taxable. The amount paid to the buyer is depreciable, although tax rules may require these items to be depreciated over a period in excess of the remaining lease term.

6. Supplies. Supplies sold with the practice will be taxed at ordinary income rates on the amount received if supply costs were previously deducted by the practice. The buyer will be able to deduct costs of those supplies as if they were purchased in

CLASSIFIED INFORMATION

Three Virginia physicians who are looking toward retirement offer practice opportunities in the Classified Ad section of this issue of Va Med:

- "For Sale—Solo family practice in Northern Virginia"
- "Norfolk—Retiring from 25-year solo practice of general surgery"
- "Family practice on Chesapeake Bay, owner retiring"

See page 222 for details.

the normal course of business.

7. Medical Charts and Records. While this is not absolutely certain, purchased patient medical charts and records *might* be treated as tangible property subject to depreciation. Useful lives of five to ten years have been claimed in many practice sales, and there are tax cases supporting such a write-off. The buyer would thus be able to deduct the portion of the purchase price allocated to medical charts and records, thereby reducing his/her after-tax cost. The seller usually has no basis in the medical charts and records, and therefore, the entire amount allocated to them will be taxable income to the seller.

8. Consulting Pay/Convenant Not to Compete. Carefully stated and documented allocations to the selling doctor's promise to provide consultative services and/or not to compete are deductible as paid by the buying doctor. The seller is taxed upon receipt on the amounts so allocated. This has been and should continue to be a popular tax-saving approach if properly structured.

Preparing to Meet a Buyer

Be prepared before you meet with the buyer. If you've opted for an appraisal, have the report in hand along with the tools the appraiser used in justifying the value. The most frequently requested items are: One year's financial statements; three to five years' tax returns; patient data reports (i.e., new patients, daily numbers seen, socioeconomic profile, referral sources); insurance profile (a breakdown of percentage of patients seen by each carrier); assets (including date acquired); fee schedules; practice promotional items; employee information; samples of the appointment book and day sheets; any contracts and leases; and finally, a brief history of the practice and an overview of the community.

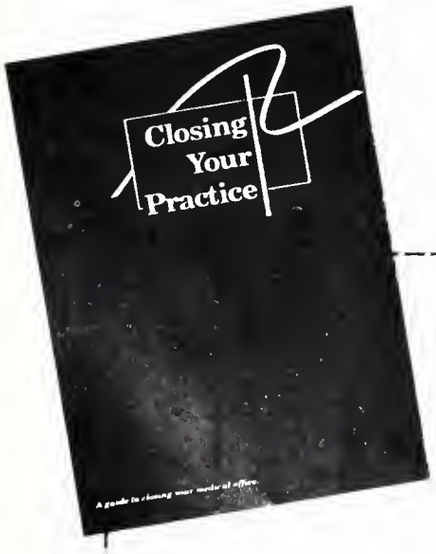
You need to be open to a serious inquiry. This is no time to paint a picture either too rosy or too unflattering. Plan to discuss frankly hospital politics, coverage, how the competition affects your practice, and the number of hours you spend working in it each year. Hold the meeting in your office and let your serious candidates see that you have nothing to hide; allow them to observe the office systems.

The Negotiated Price

Once an initial sales price has been reached, continuing negotiations between the parties should concentrate on tax allocations of the total purchase price. Because there is a give-and-take between the parties in regard to tax treatments, both may be able to restate the "deal" for their benefit.

For example, the buyer's total purchase price might be increased, but the change may give him/her greater tax deductions while reducing the allocated goodwill price. The seller might correspondingly have an increase in the amount of taxable income, but come out ahead because of the higher overall purchase price. The selling physician may be in a lower tax bracket after leaving practice, so the increased price may not be taxed as heavily.

So long as the resulting overall purchase price, considering tax treatment, keeps the selling physician's after-tax yield at least the same, everyone should be pleased.



FREE Guide

to closing a medical practice.
Prepared for Virginia physicians
by the Medical Society of Virginia.
Send this coupon for your free copy.

Name _____

Address _____

_____

Mail to Virginia Medical, 4205 Dover Road, Richmond VA 23221.

Such restructuring may help the buyer and hence help speed the sale of the practice. Fig. 1 shows how a reallocation of the sales price lowered the ultimate after-tax cost to the buyer by $15,600 and gave the seller a $2,880 after-tax increase in spite of the sales price increase from $100,000 to $104,000.

Quite naturally, the Internal Revenue Service is interested in such price structuring. In particular, new tax laws now virtually require that some of the purchase price, and perhaps much of it if you are not careful, be allocated to goodwill. The new rule essentially requires that any portion of the purchase price in excess of the "true" fair market value (and not some agreed or negotiated figure) of the purchased tangible assets (primarily equipment and furnishings) is to be allocated to nondeductible goodwill.

Reasonable allocations of the purchase price among the various assets and items described above (including goodwill) ought to be defensible without considering taxes. However, if you are too greedy, the IRS may reject your allocation if you are audited. Nevertheless, if the parties reach an agreement and the revised pricing figures are not totally beyond reason, the mutually expected tax treatment should almost certainly follow.

It is quite common for the selling physician to accept a promissory note as partial payment for the final negotiated sales price. If the selling doctor is to become the "bank," then he or she should watch for an addtional tax trap—imputed interest. The imputed interest rules today are quite complicated and involved. Suffice it to say that if the note the seller agrees to hold provides for no or low interest, the IRS will assume an appropriate interest rate as provided in the law and IRS regulations. The effect of this imputed interest rule is to convert part of the seller's purchase price allocation to interest income instead of gain from the sale of the various assets sold. Depending on the circumstances, the seller's after-tax yield may be reduced. The buyer is allowed to deduct the amount imputed as interest. As a result, the buyer's after-tax cost generally should not be adversely affected by an IRS imputed interest determination. Thus, a buyer's promissory note should not fail to reflect a definite payment period and an adequate interest rate.

Table 1. Sale Example.*

A. True Sale Price

	Price	After-Tax Yield To Seller	After-Tax Cost To Buyer
1. Equipment (assume cost basis = $10,000)	$ 15,000	$13,600**	$10,800
2. Goodwill	$ 85,000	$61,200	$85,000
TOTAL	$100,000	$74,800	$95,800

B. Revised Sale Price

	Price	After-Tax Yield To Seller	After-Tax Cost To Buyer
1. Equipment (basis = $10,000)	$ 20,000	$17,200**	$14,400
2. Covenant Not To Compete	$ 30,000	$21,600	$21,600
3. Consulting Pay	$ 20,000	$14,400	$14,400***
4. Charts and Records	$ 15,000	$10,800	$10,800***
5. Goodwill	$ 19,000	$13,680	$19,000
TOTAL	$104,000	$77,680	$80,200

*Assumes both seller and buyer are in 28% tax bracket in all years. In actuality, this will likely not be true, and calculations should be made on yearly basis, using each year's likely tax bracket for each party.

**28% tax on price above basis. Assumes all is depreciation recapture.

***These tax results are uncertain.

Insurance Protection. As a last consideration, it is imperative that your interests in the continuing practice be sufficiently guaranteed through the use of insurance (assuming you were not paid the entire purchase price for the practice). Any outstanding balance the buyer owes you should be protected through life insurance (on his or her life), possibly along with disability insurance in case of accident, illness, or injury to him or her (although requiring such disability insurance may be subject to negotiation due to its expense). You should be listed as the beneficiary. In addition, general insurance on the practice's contents should be required with you named as the loss payee. Be sure that these insurance requirements are properly included in the sales agreement. □

GOODWILL REGISTRY

For nine years The Health Care Group has provided a national clearinghouse service of goodwill valuations. Available primarily to medical practice advisors who participate by submitting actual transaction data, *The Goodwill Registry* summarizes the transactions and offers yearly updates on average values on a specialty-by-specialty basis. Your advisor may purchase the *Registry* by calling Joy Goodman at The Health Care Group, 215-828-3888.

"Our Concern Be Peace Of Mind."

Theocritus, 230 B.C.

Charles M. Cooper, M.D.

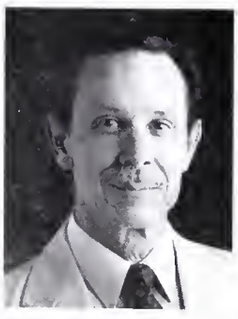
Morgan E. Scott, M.D.

Neil P. Dubner, M.D.

Arthur E. Kelley, M.D.

Basil E. Roebuck, M.D.

Don L. Weston, M.D.



Orren LeRoyce Royal, M.D.

G. Paul Hlusko, M.D.

D. Wilfred Abse, M.D.

Ronald L. Myers, M.D.

Hal G. Gillespie, M.D.

Greek poet Theocritus said it. The eleven men who comprise the Active Medical Staff of Saint Albans Hospital practice it. Every day.

They combine years of study and experience to bring patients the best available care for emotional and psychological troubles. Their special interests cover the broadest spectrum of psychiatric treatment, resulting in both adult and adolescent programs for chemical dependency, eating disorders, phobias and anxieties, and pain management.

Our doctors lead a large group of professionals and volunteers who make compassion and expert care a way of life. Saint Albans. Today and for the past 74 years we are concerned, above all, with your peace of mind.

Saint Albans Psychiatric Hospital

OUR HOME SALES ARE ON THE UPSWING.

Bert Hodson

Swing by the 500-acre golf course community of Birkdale, and you'll see why so many people wouldn't live anywhere else. Each of our homes is a perfect example of quality craftsmanship, whether traditional, Victorian, or contemporary.

Over half of them offer views of the lake and fairways. And they all offer access to the tennis, swimming, and tree-lined paths for biking, walking, or jogging.

Of course, one of the main attractions is our Dan Maples-designed championship golf course. A full-service practice range and our daily fee golf course will be open for your inspection, along with our homes.

Call us at our Information and Sales Center—(804) 739-0301 today. Here at Birkdale, the quality of English country living will always be in full swing.

Birkdale

Directions: Drive 2 miles on Rte. 360 west of the 288 Interchange, then turn left on Winterpock Road for one mile to Birkdale.

EQUAL HOUSING OPPORTUNITY

Acute Rheumatic Fever: Is It Returning to Virginia?

Michael B. Lenhart, MD, and
Duncan S. Owen, Jr., MD,
Richmond, Virginia

ACUTE rheumatic fever (ARF) is an inflammatory disease that may follow Group A streptococcal infections and may affect almost any organ system clinically. The twentieth century has witnessed a marked decline in the incidence of ARF in the developed countries, in both pediatric and adult populations.[1,2] Since the mid-1980s, however, numerous case reports have been appearing and seem to herald a resurgence of the disease.[3-6] Recently an adult was admitted to the Medical College of Virginia Hospitals with acute rheumatic fever.

Case Report

A 19-year-old black male was admitted with complaints of chest pain and fatigue. An electrocardiogram revealed a first degree A-V block and a transient second degree (Mobitz I) A-V block. An exercise thallium test was normal. Physical examination revealed a grade II/VI systolic ejection murmur but no evidence of heart failure. His symptoms improved with antacids, and he was discharged without a specific diagnosis. Five days later he returned, complaining of an acute onset of right hip and knee pain; this progressed to the point that the patient was unable to ambulate. He denied trauma, prior joint pain, drug allergies, skin rash, tick bite, penile discharge, or recent travel. The patient had no significant past medical history except for sickle cell trait, and he took no medications regularly.

At the time of admission, physical examination was significant for a temperature of 103.8°F and a grade II/VI systolic ejection murmur. A transient pericardial friction rub was heard. The right hip and knee were markedly decreased in range of motion, apparently because of pain, because only minimal swelling and heat was noted in the right knee. Admission chest radiograph was clear and electrocardiographic tracing revealed only sinus tachycardia. Laboratory data was significant for hemoglobin of 8.3g/dl and a WBC of 14,500/mm^3.

At the end of the first hospital day, the patient complained of pain and swelling in his left hand and elbow. A rheumatology consultant elicited a history of a sore throat approximately 3-4 weeks prior to admission. Aspirin, 6 gms a day, was instituted. Over the next 48 hours several other joints became symptomatic, but by 72 hours he began to improve. Laboratory studies revealed negative rheumatoid factor, antinuclear antibodies, cold agglutinins, hepatitis panel, as well as negative cultures of the blood, urine, and synovial fluid. However, an antistreptolysin O titer was 960 units (normal less than 170), erythrocyte sedimentation rate 127mm/hr, and throat culture revealed group Aβ hemolytic streptococci. He was administered 1.2 million units of intramuscular benzathine penicillin. By hospital day 10 the patient was afebrile and ambulating without difficulty. He was discharged and followup visits were arranged.

Discussion

Acute rheumatic fever is defined by the revised Jones criteria.[7] To make the diagnosis, one must have two major *or* one major and two minor criteria, plus supporting evidence of streptococcal infection.

- Major criteria: carditis, polyarthritis, chorea, subcutaneous nodules, or erythema marginatium.
- Minor criteria: previous history of rheumatic fever, elevated ESR, or prolonged PR interval.

The incidence of ARF has declined in the 20th century, with the nadir among children and teenagers occurring from 1970-1980, when the overall incidence ranged from 0.23-1.88 cases per 100,000 per year.[1] Also, the incidence decreased in the adult population to the point that mass penicillin prophylaxis for naval military recruits was discontinued in 1980.[2] In the mid-1980s there appears to be a resurgence of acute rheumatic fever, with individual case reports and outbreaks reported in Utah, Ohio, Pennsylvania, and military bases in San Diego and Missouri.[2,3,5,8] (Several pediatric cases have been seen at the Medical College of Virginia Hospitals in the past two years.)

The patient presented here met one major and three minor criteria and had streptococcal pharyngitis. Polyarthritis was the most striking feature in our patient and in adults is the most common manifestation of ARF. The pattern of arthritis is variable and ranges from the classic migratory polyarthritis to one that is progressive and symmetrical in large joints.[9] Our patient exhibited progressive arthritis that affected both large and small joints and even the temporomandibular joints. In all series reviewed (and as seen in our patient), the severity of the pain seemed disproportionate to the physical findings.[2,9] Other forms of arthritis that may be confused with ARF are "reactive arthritis" associated with enteric pathogens, disseminated gonococcal infection, and adult Still's disease. A

From the Division of Rheumatology, Allergy and Immunology, Department of Internal Medicine, Medical College of Virginia/Virginia Commonwealth University. Address correspondence to Dr. Owen at Box 647, MCV Station, Richmond VA 23298-0647.

Submitted 2-16-90.

feature of the arthritis associated with ARF is its well-described response to salicylates.[9] The newer nonsteroidal antiflammatory drugs may be as good or better but there are no data regarding these drugs.

Carditis is generally an infrequent complication in adults with ARF. In a review of adult cases since 1957, the overall incidence of carditis was 33% (range 18-56) and in the recent outbreak in San Diego it was 30%.[6] Clinically, carditis is manifested by one of the following: organic cardiac murmur not previously present, cardiomegaly, congestive heart failure, or pericarditis. Conduction disturbances do not necessarily indicate acute carditis.[7] Our patient initially presented with a systolic ejection murmur and later developed a pericardial rub; however, echocardiography failed to reveal an effusion. Our patient had no evidence of chorea, erythema marginatum, or subcutaneous nodules. These are rare in adults and are seen generally in less than 5% of the cases.[10] While not part of the revised Jones criteria, our patient presented with microcytic anemia. Despite an extensive workup, no definite etiology of the anemia could be determined. It is interesting that all ten patients in the San Diego military recruit study also had a "significant anemia."[6]

The treatment of rheumatic fever must be concerned with three separate aspects of the disease:

1. The precipitating streptococcal pharyngitis is treated conventionally with a 10-day course of oral penicillin. If compliance is a problem, a single intramuscular injection of benzathine penicillin 1.2 million units (for adults) is administered.

2. The inflammatory polyarthritis is treated with 4-8 grams per day of aspirin along with bed rest. The duration of treatment is guided by response with approximately 80% of patients responding (pain-free) by six weeks and greater than 90% responding by 12 weeks.[1] Our patient showed improvement within three days and at a four-week followup was pain free. With carditis, the use of corticosteroids is still somewhat controversial but many would give them if congestive heart failure developed.

3. The third arm of therapy is prophylaxis for recurrent rheumatic fever. The recommended protocol is 1.2 million units of IM benzathine penicillin every four weeks for a minimum of five years after the last attack.[1] If carditis is present, life-long therapy is probably warranted.

Summary

In summary, rheumatic fever seems to be on the rise in the United States. It remains to be seen whether this case is an example of a resurgence of ARF in adults in Virginia, but it probably does, since there are a number of cases being seen in the pediatric population.

References

1. Pope R. Rheumatic fever in the 1980s. Bull Rheum Dis 1989;38:1-8
2. Leads from the MMWR. Acute rheumatic fever among army trainees—Fort Leonard Wood, Missouri, 1987-1988. JAMA 1988;260:2185-2188
3. Kaplan EL, Markowitz M. The fall and rise of rheumatic fever in the United States: a commentary. Internat J Cardiol 1988;21:3-10
4. Bisno AL. Acute rheumatic fever: forgotten but not gone. N Engl J Med 1987;8:476-478
5. Veasy LG, Wiedmeier SE, Orsmond GS et al. Resurgence of acute rheumatic fever in the intermountain area of the United States. N Engl J Med 1987;316:421-426
6. Wallace MR, Garst PD, Papadimos TJ, Olofierd EC. The return of acute rheumatic fever in adults. JAMA 1989;262:2557-2561
7. Bisno AL. Rheumatic Fever. *In* Wyngaarden JB, Smith LHjr (eds). Textbook of Medicine, 17th Ed. Philadelphia, W.B. Sanders Co., 1985
8. Mund DJ. Rheumatic fever in adults. Ann Intern Med 1979;90:435
9. McDonald EC, Weisman MH. Articular manifestations of rheumatic fever in adults. Ann Intern Med 1978;89:917-920
10. Bates RC. Acute rheumatic fever: a study of 132 cases in young adults. Ann Intern Med 1958;48:1017-1025

Help for a troubled friend is only a phone call away.

If you suspect a colleague is experiencing problems with alcohol or drug abuse, don't contribute to the "conspiracy of silence," call The Medical Society of Virginia's Physicians' Health and Effectiveness Committee. A non-punitive approach through rehabilitation *is* an alternative. Your report will be kept confidential. Ask for Jeanne Douglas at MSV headquarters, (804) 353-2721.

Ankylosing Hyperostosis of the Spine: Case Report

L. Ormandy, MD, and R. G. Riddick, MD,
Washington, DC

THE purpose of this paper is to present a case of ankylosing hyperostosis of the spine (AHS) and review the literature on this rare disease.

Case Report

A 44-year-old retired lieutenant colonel of South African origin was referred to the orthopedic clinic because of limited flexion of neck motion and numbness of each hand. The patient did not have dysphagia. The physical examination showed moderate loss of neck flexion with slight discomfort. The sensory examination was negative. The reflexes of the upper extremity were within normal limits. The patient stated that in the past few weeks the numbness of the hands had subsided, and he was completely asymptomatic.

The glucose tolerance test was negative.

Roentgenogram showed exuberant anterior osteophytes with bony bridges continuous with the anterior vertebral cortex, the anterior longitudinal ligament, and the annulus fibrosus of the intervertebral discs. There was a lack of involvement of the apophyseal joints (Fig. 1). The bony density was within normal limits. The posterior walls of the vertebrae were not affected. There was no posterior ligamentous ossification. The neural foraminae were clear (Figs. 2A, 2B).

In this case the patient had minimal symptoms and did not require treatment.

From the Walter Reed Army Medical Center, Washington, DC. Address correspondence to Dr. Ormandy at 6374 Lakeview Drive, Falls Church VA 22041.

Submitted 12-16-89.

Discussion

Forestier and Lagier described AHS in 1971,[1] and it is called "Forestier's disease." It is a distinct entity which may be readily distinguished from osteoarthritis, ankylosing spondylitis, spondylosis, and postinfectious and posttraumatic changes in the vertebrae, although all of these conditions may produce osteophytes.[2] It is found more frequently in male patients. The onset of symptoms is approximately 50 years.[1]

AHS has the following distinguishing features: The bony osteophytic bridges are continuous with the anterior vertebral cortex. The ligamentum longitudinale anterius is partially integrated into the bony proliferations at the level of the vertebral edges and at the pre-disc spaces. The vertebral cortex is thickened but rarely associated with osteoporosis.[1] The disc spaces are normal in height and the vertebral plates are regular in appearance. The apophyseal joints are not involved.[1] The ossifications are not present on the posterior wall of the vertebral bodies as disc spaces.[1] In certain instances, a widening of the spinal processes is noticeable (Bastram syndrome).[3] The association of hyperostosis and diabetes mellitus indicated by Boulet has been proven to be frequent.[4,5] Spinal pain may be absent or moderate. Dysphagia can be present when AHS of the spine involves the cervical spine.

Physical examination reveals diminished spinal motion, particularly in the lower dorsal spine, where the bony bridges are more frequent. Spinal rigidity is never severe and thoracic cage motion is normal. AHS of the spine may involve the cervical, dorsal and lumbar spine.[1]

As to differential diagnosis, AHS is to be differenti-

Fig. 1 (left). Exuberant anterior osteophytes demonstrate bony bridging continuous with vertebral cortex. Figs. 2A (center) and 2B (right). Neural foraminae demonstrate no osteophytic encroachment on oblique views.

ated from the following four conditions:

1. In spondylosis deformans of Schmorl,[6] the marginal osteophytes do not lie on the border of the vertebral body. They form on its exterior surfaces at a point where the cartilagenous marginal plate enters in contact with the vertebral body.
2. In osteoarthritis of the spine, the interapophyseal joints are involved.
3. In ankylosing spondylitis,[3] the bony bridges are thicker and involve the interapophyseal, costotransverse and sacroiliac joints. The radicular type of pain comes from the lesion of the interapophyseal joints of the cervical spine.
4. In postinfectious and posttraumatic hyperostosis, the hyperostoses are secondary to the adjacent deterioration. In these cases the clinical features are minor, prognosis is good, and no special treatment is necessary.

Summary

Ankylosing hyperostosis of the spine is described as osteophytic spurs or anterior osseous bridges with thickening of the corresponding vertebral cortex. The ossification includes the ligamentum longitudinale anterius and the peripheral part of the disc. Our patient had minor complaints but at the time of consultation was symptomatic.

Gratitude is extended to Miss Melissa Gates and Dr. John Long for their help with this manuscript.

References

1. Forestier J, Lagier R. Senile ankylosing hyperostosis of the spine. Clin Orthop 1965;74:65–83.
2. Meeks LW, Renshaw TS. Vertebral osteophytosis and dysphagia. J Bone Joint Surg 1973;55A:193–201.
3. Epstein BS. The Spine. Philadelphia, Lea and Febiger, 1976, pp 382–384.
4. Boulet P, Serre HJ, Mirouze J. Le rachis diabetique. Sem Hôp Paris 1954;30:2392.
5. Ott VR, Schwenkenbecher H, Iser H. Die Spondylose bei Diabetes mellitus. Z Rheumaforsch 1963;22:278.
6. Greenfield GB. Radiology of Bone Diseases, 2nd Ed. Philadelphia, J. B. Lippincott Co., 1975, p. 616.

Bilateral Tubal Pregnancy: Case Report

Fadi A. Bsat, MD, and Sidath Jayanetti, MD,
Norfolk, Virginia

Case Report

A 31-year-old black woman, gravida 4, para 0, aborta 3 (two induced and one spontaneous, all first trimester), at 6.5 weeks gestation by dates, presented with vaginal bleeding and lower abdominal cramping of two weeks duration. The patient's beta human chorionic gonadotropin (BHCG) level on admission was 1980 mIU/mL, whereas four and seven days earlier, when she was evaluated by the emergency room staff, it was 1950 mIU/mL and 1100 mIU/mL respectively. The patient gave a history of gonorrhea pelvic infection in 1977, as well as repeated Bartholin cysts. She used no contraceptive method and was on no medication. On physical examination the vital signs were stable, abdominal examination revealed no tenderness and no masses, with good bowel sounds. Pelvic examination was positive for mild bleeding per cervical os, normal size uterus, and a right adnexal mass tender to palpation. Left adnexa was normal. Ultrasonography confirmed the pelvic examination, with presence of fluid in the cul-de-sac.

The patient underwent laparoscopy and laparotomy for suspected right ectopic pregnancy and was found to have a right ectopic ampullary gestation of $2 \times 1.5 \times 1.2$ cm in size, and a left ectopic ampullary gestation of $1 \times 1.5 \times 1.5$ cm in size. A right salpingostomy, a left partial salpingectomy, and inspection of intraabdominal structures were done. The patient's postoperative course was uncomplicated.

Pathology revealed partly degenerated large choronic villi from the right ectopic, and young chorionic villi from the left ectopic. No evidence of inflammatory changes was found on either fallopian tube.

Discussion

Ectopic pregnancy is one in which implantation of the fertilized ovum occurs outside the endometrial cavity. The incidence of ectopic pregnancy in the United States is now about one of every 100 reported pregnancies.[1] Combined pregnancy is a tubal pregnancy that coexists with an intrauterine pregnancy. It

From the Department of Obstetrics/Gynecology, Eastern Virginia Medical School. Address correspondence to Dr. Bsat at PO Box 1980, Norfolk, VA 23501.

Submitted 12-19-89.

occurs in about one in 30,000 births[1] and can be complicated by a third pregnancy in the opposite tube.[2] Twin tubal pregnancy has been also reported, with both embryos in one tube[3] or one in each tube. Olive et al reported a bilateral tubal pregnancy following gamete intrafallopian transfer (GIFT).[4]

Theoretically, the incidence of bilateral tubal pregnancy should be the result of multiplying the incidence of twin pregnancy by the incidence of ectopic pregnancy in each tube; that is 1/89 × 1/100 × 1/100, or one pregnancy in 890,000. This value may be clinically smaller, however, since some of the ectopic implantations may die and resolve spontaneously, or more rarely develop into a fetus papyraceous.

Tubal pregnancy remains an uncertain diagnosis, but it should always be part of the differential diagnosis when indicated because of its potentially serious complications. Tubal pregnancy is still responsible for 14% of all maternal deaths.[5] Tubal causes for ectopic pregnancy, such as chronic salpingitis, remain variable in the literature, ranging from 5% to 90%.[6,7]

Summary

One important conclusion should be made. When a laparoscopy or laparotomy is done, one should take full advantage of this by inspecting and/or palpating the second tube, the ovaries, and most pelvic and abdominal structures. Incidental diagnosis may prove to be at times as important as the one for which the surgery is being done.

References

1. Cunningham FG, MacDonald PC, Gant NF. Ectopic pregnancy. *In* Cunningham FC, MacDonald PC, Gant NF. Williams Obstetrics. Norwalk, Connecticut, Appleton & Lange, 1989, p 511.
2. Funderburk AG. Bilateral ectopic pregnancy with simultaneous intrauterine pregnancy. Am J Obstet Gynecol 1974;119:274-276.
3. Ascarelli M. Unilateral twin ectopic gestation. A case report. J Reprod Med 1989;34:850-852.
4. Olive DL, Taylor N, Cothran GE, Schenken RS. Gamete intrafallopian transfer (GIFT) complicated by bilateral ectopic pregnancy. Fertil Steril 1988;49:719-720.
5. Brumstead J, Kessler C, Gibson C, Nakajima S, Riddick DH, Gibson M. A comparison of laparoscopy and laparotomy for the treatment of ectopic pregnancy. Obstet Gynecol 1988;71:889-892.
6. Persaud Y. Etiology of tubal ectopic pregnancy. Obstet Gynecol 1970;36:257-260.
7. Dubuisson JB, Aubriot FX, Cardone V, Vacher-Lavenu MC. Tubal causes of ectopic pregnancy. Fertil Steril 1986;46:970-972.

HERE'S ONE CASE OUR ADDICTION SPECIALISTS RARELY SEE.

You could probably say we've seen it all at the University Center for Addictive Behavior. Our patients range from the abuser to the severely addicted; from the adolescent to the older adult.

But even with our diverse caseload, you'll hardly ever see anyone being admitted to the hospital. Because we help patients overcome their problems without hospitalization, through comprehensive programs, which are conducted on an outpatient basis. Even chemical withdrawal can be done without the patient being admitted.

Of course, sometimes a patient will need to be hospitalized. We can arrange to do so on a short-term basis, until those patients are ready for one of UCAB's out-patient programs, exclusively staffed by MCV faculty.

If you know someone who needs addictions treatment, no matter how slight or how severe their problem, call UCAB. We're here to help stop their addiction. Case closed.

M C V UCAB HOSPITALS

Conveniently located in the West End. The Forum Executive Center, 10124 West Broad Street, Glen Allen, Virginia, (804) 662-7172

ABSTRACTS

These abstracts derive from the scientific session of the annual meeting of the Virginia Dermatological Society on November 12, 1989, in Richmond. Dr. Robert J. Pariser was program chairman.

Yellow Nail Syndrome. Bonnie F. Straka, MD, Charlottesville.

A 74-year-old man was hospitalized because of recurrent pleural effusions, causing shortness of breath, and ankle edema. He had a 10-year history of abnormal fingernails and toenails which showed thickening, yellowish discoloration, slow growth, and increased transverse and longitudinal curvature. There was also some onycholysis and cross-ridging. Hospital workup which included bronchoscopy, thoracentesis, pleural biopsies and CT scans, failed to reveal any evidence of malignancy or infection. In addition, he had weight loss, fatigue, and anorexia. The patient underwent thoracoscopy with talc pleurodesis. Two days later, however, he developed a cold, pulseless left leg which required emergency left femoral endarterectomy, embolectomy and fasciotomy. He deteriorated rapidly thereafter and died several hours later of acute cardiopulmonary arrest.

The yellow nail syndrome in its full-blown form involves a triad of yellow nails, primary lymphedema, and recurrent pleural effusion. These findings are thought to be secondary to congenital hypoplasia of the lymphatics. This full triad is not seen in all patients and early in its development the nail changes may be the only clinical signs. There is no known therapy for the nail disease. Medical therapy centers around control of peripheral edema and management of pulmonary complications.

Wegener's Granulomatosis Presenting with Migratory Polyarthritis and Leucocytoclastic Vasculitis of the Skin. Barbara T. Sitton, MD, Charlottesville.

A 23-year-old man was seen because of a low-grade fever, migratory polyarthritis, and a petechial rash. His past history included a recent tick bite, antibiotic treatment for tooth extraction, and recent episodes of epistaxis. He developed some blistering of the feet which showed no organisms on culture. He was treated with ceftriaxone and doxycycline for a differential diagnosis of gonococcal arthritis vs Lyme disease; however, his arthritic symptoms worsened and the rash became more purpuric. In addition, he developed conjunctivitis with subconjunctival hemorrhage. A skin biopsy at this time revealed leukocytoclastic vasculitis. Prednisone therapy was begun for a diagnosis of serum sickness-like reaction. One week later, he developed sinus tachycardia with primary A-V block. He developed some nasal inflammation and was found to have evidence of sinusitis on CT scan. Hematuria and proteinuria subsequently developed. Examination revealed a thin young man with tenderness and effusion over the right wrist, right knee and left ankle. There was extensive, palpably purpuric, eruption primarily of the lower extremities and trunk. There was bilateral conjunctivitis with sunconjunctival hemorrhage. Biopsy of the skin showed prominent leukocytoclastic vasculitis associated with deposition of IgM and C-3 in the perivascular dermis. Renal biopsy showed segmental sclerosis and necrosis of glomeruli and fibrin deposition. One glomerulus was surrounded by granulomatous inflammation.

Wegener's granulomatosis is characterized by the triad of necrotizing granulomatous lesions primarily of the upper and lower respiratory tract, necrotizing vasculitis of the lungs and sometimes other sites, and renal disease manifested as necrotizing glomerulitis with granulomatous inflammation of the extraglomerular tissue. Continuous lesions are said to occur in up to one half of patients. These lesions consist of necrotic papules and/or nodules, ulcers, and petechial and ecchymotic lesions.

Relapsing Polychondritis. Peter Jaber, MD, Charlottesville.

A 69-year-old man presented with a one-month history of pain and swelling in the left ear and in the nose, unresponsive to treatment with dicloxacillin and prednisone. He had no history of arthralgias, hoarseness, dyspnea, fever or other systemic symptoms. Examination showed marked warmth, redness, tenderness and induration of the left ear with sparing of the ear lobe. There was also mild swelling over the bridge of the nose. Laboratory data included a white count of 15.4 with 82% polymorphonuclear leukocytes, an erythrocyte sedimentation rate of 60, a negative ANA, and negative rheumatoid factor. A biopsy of the left ear revealed chondritis and perichondritis with fibrillar degeneration of the connective tissue. Initial treatment included prednisone 60 mg a day and dapsone gradually increased to 150 mg a day over a 3-week period. When the dose of prednisone was tapered below 40 mg a day, his disease recurred with inflammation and hearing loss in the right ear. A saddle-nose deformity was noted at this time. Dapsone was increased to 200 mg per day but the inflammation persisted. At this point, dapsone was discontinued and cholchicine 0.6 mg bid was added with a continued

prednisone dose of 35 mg a day. On this regimen, he developed definite improvement of symptoms in one week.

Relapsing perichondritis is manifested clinically as recurring inflammation of the cartilage of the ears, nose, and occasionally trachea, sometimes associated with arthritis, ocular inflammation, audiovestibular damage and, less frequently, cardiovascular damage. Approximately 30% of patients have associated connective tissue disease. The disease typically goes through periods of exacerbation and remission. Treatment traditionally centers around the use of prednisone and/or dapsone.

Angiokeratoma Circumscriptum. David M. Pariser, MD, Norfolk.

A white female infant was noted at birth to have large, bulky, vascular tumors on the anterior and medial aspects of the left leg and foot. In some of the areas, particularly the dorsum of the left great toe, there was deep ulceration. Areas of crusting and hyperkeratosis were evident within the lesion. There was no family history of vascular anomalies. Topical therapy with hydrogen peroxide soaks and silver sulfadiazine cream resulted in healing of the ulcerations over a 2-week period; however, the size of the lesion itself remained unchanged.

Four types of angiokeratoma are generally recognized, namely, angiokeratoma circumscriptum, angiokeratoma of Mibelli, angiokeratoma of the scrotum and vulva, and angiokeratoma corporis diffusum (Fabry). The circumscriptum type most commonly presents as a congenital lesion, typically on the lower leg and foot. The lesions have a deep, bluish-red color and sometimes have a linear or zosteriform distribution. Hyperkeratosis and crusting are typically seen. Unlike other hemangiomas of infancy and childhood, these lesions show no particular tendency to involute.

Angiolymphoid Hyperplasia with Eosinophilia. R. B. Henry, III, MD, Norfolk.

A 30-year-old woman developed enlarging nodules behind her left ear. The lesions were painless but did bleed upon minor trauma. In addition, she complained of a pulsating sensation in the ear. Physical exam showed mutiple subcutaneous nodules of the left pinna on both front and back surfaces as well as on the adjacent scalp. Clinical diagnosis of angiolymphoid hyperplasia with eosinophilia was confirmed by histologic examination, which revealed dilated thin-walled blood vessels having plump endothelial cells. Stroma contained collections of lymphocytes and many eosinophils. Intralesional steroid injection and piecemeal laser ablation were unsuccessful. En bloc surgical excision is being considered.

Angiolymphoid hyperplasia with eosinophilia manifests as persistent papules and nodules typically of the head and neck region. The ears are a common site. The lesions have been variously interpreted as inflammatory and as neoplastic. Their behavior is benign. The pathogenesis is obscure. Treatment consists of surgical excision or ablation.

Rhabdomyomatous Mesenchymal Hamartoma. George Elgart, MD, Richmond.

A 3-month-old infant, a healthy boy, was seen for the presence of a "skin tag" that had been present at birth. The lesion was stable and was removed for cosmetic reasons. The nodule, clinically, was soft and mobile without fixation to underlying structures. A histopathologic examination showed a relatively normal epidermis. Pilosebaceous units were present. Centrally, there was a moderate amount of mature adipose tissue. Throughout the dermis, most prominently between the appendages and the adipose tissue, were randomly arranged intersecting bundles and fascicles of striated skeletal muscle. Immunohistochemical examination was positive for the presence of myoglobin, vimentin, desmin, and actin. S-100 protein staining was negative for neural elements.

Rhabdomyomatous mesenchymal hamartoma of the skin was the term given to a recent entity first described in 1989 as a skin tag-like growth of the newborn whose most characteristic histopathologic feature was the presence of skeletal muscle as described above.

Generalized Morphea Versus Progressive Systemic Sclerosis with Bullae. Robert B. Scoggins, MD, James W. Patterson, MD, and Duncan S. Owen, Jr., MD, Richmond.

A 62-year-old woman had a gradually progressive disorder consisting of leg tenderness, particularly in the Achilles region, and swelling of the extremities eventuating in firm skin. She had a 20-year history of bluish discoloration of the fingertips when exposed to cold. Blistering occurred on her right shin and slowly evolved to involve both shins and forearms. She had no signs or symptoms of internal organ involvement. Examination showed tense, firm skin from the dorsum of the feet to the buttocks, with sparing of the medial thighs. The forearms and much of the upper arms were similarly involved. A well-demarcated white plaque was present on the abdomen. There were some vesicles on the right shin. On later examination she showed confluent vesicles and bullae, some of which were hemorrhagic, and linear configuration on both shins and on the dorsum of the forearms. Laboratory studies showed normal hemogram, urinalysis, and routine chemistries. Anti-SCL-70 antibody and rheumatoid factor was negative. ANA was positive at a titer of 1:160 in 1988 although subsequent determinations were negative. A biopsy of the skin of the right leg was taken which showed epidermal acanthosis and hyperkeratosis, sclerosis of the dermis and subcutaneous adipose septa as well as the underlying fascia.

We've been defending doctors since these were the state of the art.

Turn of the century trephine for cranial surgery and tonsillotome for removing tonsils.

These instruments were the best available at the turn of the century. So was our professional liability coverage for doctors. In fact, we pioneered the concept of professional protection in 1899 and have been providing this important service exclusively to doctors ever since.

You can be sure we'll always offer the most complete professional liability coverage you can carry. Plus the personal attention and claims prevention assistance you deserve.

For more information about Medical Protective coverage, contact your Medical Protective Company general agent.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Ted J. Pandak, David R. Fuller
Suite 205, 7275 Glen Forest Drive Richmond, Virginia 23226, (804) 285-4131

Focal inflammatory infiltrates in which there were lymphocytes and plasma cells were present in the upper dermis, at the dermal subcutaneous junction, and in the deep subcutis. Likewise, the fascia was diffusely infiltrated with inflammatory cells with some extension into the skeletal muscle. Atrophy of dermal appendages was noted. Eosinophils were not present. Alcian blue stain failed to find any evidence of mucin deposition. Treatment has consisted of prednisone in doses of 7.5–15 mg daily which has produced little clincial response.

Hemorrhagic bullae surmounting lesions of cutaneous morphea have been reported rarely. Such cases raise the issue of the relationship of localized morphea to lichen sclerosis et atrophicus which also can have blistered lesions. In some patients, distinguishing between these two entities may not be possible.

Lymphocutaneous Sporotrichosis. Sharon S. Camden, MD, Richmond.

A 71-year-old woman developed an ulcerated lesion on the dorsum of her right hand. In addition, she had multiple erythematous firm nodules located on the right forearm and upper arm in a lymphatic distribution. The patient gave the history of being a rose gardener and of working with sphagnum moss. No axillary adenopathy was present. A skin biopsy showed the findings of cutaneous sporotrichosis. Organisms were identified on PAS stains.

This most common presentation of cutaneous sporotrichosis occurs as a primary inoculum followed by proximally distributed nodules progressing up a lymphatic chain. Diagnosis is commonly suspected on skin biopsy although organisms are few and may not be identifiable. Diagnosis is confirmed by culture. Classic treatment consists of oral administration of saturated solution of potassium iodide in an increasing dose to tolerance. Treatment usually lasts for about two months or for 30 days after disappearance of lesions.

Pemphigus Vulgaris. Beverly S. Darwin, MD, Richmond.

A 59-year-old black male developed blistering and erosions of the face, scalp, oral mucosa, trunk and proximal extremities. Skin examination showed 1–5 cm weeping, crusted erosions with peripheral borders of tense, flaccid bullae. Nikolsky's sign was negative. The oral mucosa had superficial bullae and erosions. Skin biopsy showed suprabasal acantholysis of the epidermis and direct immunofluorescence revealed the presence of IgM, IgG, IgA and C-3 in the intercellular spaces between keratinocytes. Indirect immunofluorescence showed the presence of circulating antibody to the intercellular region of epithelium in a titer of 1:2560. Initial treatment consisted of prednisone 90 mg per day with gradual resolution of the lesions. This dose was reduced to 60 mg per day, at which point azathioprine 50 mg per day was added as a steroid-sparing measure. Two months after onset of therapy, his circulating antibody titer had dropped to 1:320. After five months of therapy, his prednisone dose was 20 mg a day and the azathioprine dose continued at 50 mg per day.

Pemphigus vulgaris is a classical autoimmune primary bullous disease of the skin which confers a high mortality if untreated. Systemic corticosteroids are life-saving. More recently, treatment has tended to consist of immunosuppression plus steroids, which seems to allow for reduction of steroid dose and side effects. Many patients, if maintained relatively lesion-free, will enter periods of remission after a number of years.

Pityriasis Rubra Pilaris. Neeraja C. Matty, MD, Richmond.

A 56-year-old white man developed redness and fine scaling of the scalp and face 2 weeks after an episode of contact dermatitis. For the next month, he noted gradual thickening and scaling of the palmar and plantar skin. Soon thereafter, he developed a generalized erythroderma. Examination showed salmon-colored erythema with islands of normal appearing skin. There was scaling over the scalp, face and extremities. There was yellowish palmoplantar hyperkeratosis. The nails showed subungual hyperkeratosis. The mucosa was normal and there was no lymphadenopathy. A skin biopsy showed horizontal and vertical alternating orthokeratosis and parakeratosis of the upper dermis. Treatment initially consisted of oral methotrexate 5 mg a day for 5 days followed by 2 days off drug. Initial improvement was noted, but after completing three such courses, the patient developed fever of unknown origin with signs of high output heart failure. He died shortly thereafter.

Pityriasis rubra pilaris is a relatively rare papulosquamous disease of unknown cause which, in its full-blown adult form, shows a widespread symmetric salmon-colored erythroderma associated with hyperkeratosis of the palms and soles and sometimes follicular lesions. Although typically grouped in the category of psoriasis-like conditions, it is much more recalcitrant to therapy than is psoriasis. The course tends to be prolonged.

Squamous Cell Carcinoma of the Lip. Ricardo G. Mora, MD, Norfolk.

A 25-year-old white man developed a rapidly growing lesion of the lower lip. He was a cigarette smoker. Examination showed a 1.5-cm granulomatous indurated lesion of the left lower lip. There was no palpable lymphadenopathy. A skin biopsy revealed squamous cell carcinoma. The patient underwent Mohs micrographic surgery in three stages involving seven sections, producing a resultant defect of 3.0 × 1.5 cm. Following plastic surgery consultation, it was decided

ORTHOPEDIC SURGEONS: BROADEN YOUR EXPERIENCE.

Your time and talent are valuable. They're valuable to the Army Reserve, too. We'll pay you for a small fraction of your time, not only in money, but with big opportunities and challenges you won't find in civilian practice.

- You'll have flexibility in how and when you participate.
- You'll be offered conferences and continuing education.
- You'll have opportunities for military training in areas like Advanced Trauma Life Support, Parachuting, Flight Medicine and Mountaineering.
- You'll work with top, dedicated professionals.
- You'll have the rank and privileges of an Army officer.

If you want more information about the Army Reserve, or if you would like to talk to an Army Reserve physician, our experienced Army Medical Counselors can assist you. Call collect or write:

Mayor Wayne S. Young
P.O. Box 10165
Richmond, VA 23240-0165
804-771-2401

BE ALL YOU CAN BE.®

ARMY RESERVE

to allow the wound to heal by secondary intention. Satisfactory healing was achieved in 4 weeks.

Squamous cell carcinoma of the lip is a potentially lethal tumor, carrying a much more grave prognosis than the more common squamous cell carcinoma of sun exposed skin. Standard surgical excision using wedge resection gives an 87% 5-year cure rate. Radiation therapy has been reported to result in cure rates of 77%. The cure rate of a large series of cases done by Mohs micrographic surgery is 94%. Lymphatic involvement is said to be present in 18% of lesions greater than 2 cm. This patient's young age was unusual for this lesion, emphasizing the fact that any new or persistent lesion of this area should be diagnosed by biopsy.

Two Cases of Atrophoderma of Pasini and Pierini. Robert J. Pariser, MD, Norfolk.

A 36-year-old black woman was seen because of the development of an asymptomatic lesion of the right posterior shoulder three weeks previously. Her past medical history was unremarkable. She denied any injections or trauma to the affected area. Examination showed a 2-cm sharply defined area of atrophy and hypopigmentation which was round in shape and showed a well-defined "cliff-drop" border. The lesion was soft and pliable. A skin biopsy showed reduction in normal dermal thickness with normal collagen and no inflammatory infiltrate. No treatment was given. Followup by telephone seven years and nine months later indicated the lesion had gradually healed, leaving a flat scar.

A 32-year-old black woman noted a gradual onset of lesions on her back. The lesions were asymptomatic. There had been gradual extension from the original site on the right upper back to the right shoulder and the right arm. Her past medical history was unremarkable. There was no history of trauma or injection to the area. Examination showed multiple ovoid and linear areas of sharply defined indentation of the skin with a "cliff-drop" edge. Many of the lesions were hyperpigmented. The texture of the skin was normal. There was no evidence of sclerosis. A previous medical workup had shown no systemic abnormalities. Biopsy of the affected area and of the adjacent normal skin showed thinning of the affected dermis. There was a mild superficial perivascular inflammatory infiltrate. The size, staining and patterning of collagen bundles was normal.

Originally described by Pasini in 1923 and Pierini in 1936, this entity usually presents as asymptomatic single or multiple areas of dermal atrophy. Unlike localized scleroderma, the affected skin is soft and pliable. No evidence of sclerosis, except perhaps late in the course of the disease when some lesions appear to heal with scarring. An unusual variant of the condition involves linear lesions as seen in the second patient noted above. There is no apparent relationship to systemic disorders. No treatment has been reported successful in arresting the process.

Post-Traumatic (Surgical) Blistering of Unknown Etiology. Ricardo J. Mora, MD, Norfolk.

A 68-year-old white woman underwent Mohs micrographic surgery because of a Bowenoid basal cell carcinoma of the left leg which had been present for two years. The resulting defect was 3.75 × 2.75 cm following three stages of excision and nine sections. The defect was closed with a split thickness skin graft from the left anterior thigh. Six weeks postoperatively she developed blistering at the superior edge of the previously well-healed donor site. This was resolved spontaneously but recurred approximately two weeks later. Two days later she developed vesicopustulation at the inferior edge of the graft which resolved in one week with compresses. Four months later additional recurrences were noted. Subsequently, she had done well with no further recurrences. Due to previously used Polysporin® ointment, she was patch tested to look for possible contact allergy but none was found. Cultures and stains from the lesions have been negative. A biopsy revealed sub/intraepidermal blistering with eosinophilia. Direct immunofluorescence was negative for IgA, IgM, IgG and complement.

Localized blistering at a surgical site could be due to contact dermatitis, localized bullous pemphigoid, lymphatic obstruction or other localized vesicobullous disease. No specific etiology could be implicated in this case.

Generalized Plane Xanthomatosis With Monoclonal Gammopathy. Kenneth E. Greer, MD, Charlottesville.

An 82-year-old white woman developed gradually progressive yellowish-flat lesions of the face and neck over a 3-year period. The lesions slowly progressed to involve an extensive area of the chest and upper back. They were asymptomatic. The patient had a normal serum lipid profile but was found to have an IgG Kappa monoclonal gammopathy. She showed no clinical response to lovastatin 20 mg daily and prednisone 20 mg daily. A skin biopsy showed scattered mononucleated and multinucleated xanthoma cells in the superficial dermis. Her cholesterol level was 176 and triglycerides 70. Immunofluorescence revealed complement and immunoglobulin within some of the lipid deposits. Bone marrow examination was normal.

Disseminated xanthomatosis of several types, including plane xanthomas, has been associated with monoclonal gammopathy. In some cases, this appears to be a benign serologic finding; in others, the association has been with myeloma. Treatment in such patients has been disappointing.

VIRGINIA MEDICAL

EDITORIAL

Changes

THIS started out to be a short editorial on the changing faces of medicine in Virginia, with mention of a few of those recently deceased or who have retired from practice. Achievement of this goal is just not possible. Mention might be made of a few of those retiring in Richmond—Wash Winn, Emmett Mathews, Joe Parker, Walter Bundy, Herb Park, Dennis Morey, and Joe Coxe, as well as a sprinkling of others throughout the state as mentioned elsewhere in this issue. Among those recently deceased are John Lynch, Jim Blades, Colon Rivadeneira, and Peter Pastore, all of Richmond; Epes Harris, Blackstone; Bob Neu, Arlington; and Cully Lippard, Lynchburg. And the above constitute only a few of those no longer in practice in Virginia.

For many of those retiring from practice the wrench has not been too great. The practice of medicine today has become a business, pure and simple. The physician is now a "health care provider." Patients are not always friends; often they present as adversaries. Hospitals, in former days the physician's workshop, are a different entity; Blue Cross-Blue Shield, "the doctor's insurance plan," can no longer qualify as such. Medicare and Medicaid present progressively stricter rules, with ever lower renumeration to the practicing physician.

There is a light at the end of the tunnel. Medicine in the United States still is the best in the world. If you were among those who attended the symposium on "Health Care in Other Countries," recently sponsored by St. Mary's Hospital, you are encouraged. Keep working!

E.L.K., JR.

The Hawk

IT was a hot day in early summer. I had been working so long and so hard in the weedy garden that I was exhausted and soaked with sweat. To cool off I lay on the grass in the shade of the Montmorency cherry tree. As I gazed into the hot, cloudless, blue sky, I saw the hawk gliding and soaring in the air currents high above me.

I was fascinated by its uncanny ability to find updrafts so that with effortless grace it could soar over the countryside. And as I watched, I remembered that birds of prey have extraordinarily keen sight plus two foveas in each eye, twice as many as humans.

Not only do birds of prey have exceptional vision to spot their quarry, but they also have a panoramic view of the world. They have binocular vision directly in front of them with only a small blind area directly behind them.

As I cooled and contemplated, I wondered if their eyesight might be so good that they literally could see into us. I wondered if they could see through our veneer of civility and into our core, our id, that secret place of secret places where our crassness, rudeness, selfishness, thoughtlessness, dark thoughts and hostility reside.

If I knew the answer, I would know how opaque my gardening clothes and cap should be.

H. S. CAMPELL, MD

HISTORICAL NOTES

How We Got Here: Case Report From the Class of 1904

EARLY in this century G. B. Shaw said, "We have not lost faith, but we have transferred it from God to the medical profession." Paul Starr recently gave a memorable subtitle to his book, "The rise of a sovereign profession and the making of a vast industry."[1] Starr's book charted the large forces behind the ascendancy of the profession between 1900 and 1980: scientific progress in control of many diseases, urbanization and rising public expectations, and distribution of medical costs by insurance. Another of these forces was reputed to be a decrease in the number of medical schools and students early in the century, achieved by raising academic standards, either because of scientific ideals or monopolistic design, depending on different readings of the same data.

Because history includes both the tracing of such large forces, and individual and personal views from the time, I offer this recorded interview about medical education at the University of Virginia with my uncle, Dr. H. Norton Mason of Richmond, who was 94 years old at the time of our conversation.

Uncle Norton entered the University of Virginia in 1900 and received the MD degree in 1904. At that time there were relatively few formal requirements in terms of premedical courses, no MCAT and less competition, and the doctorate could be reached by two years of classes in medical sciences after some evidence of basic preparation.

Uncle Norton had probably prepared for our interview, as suggested by his careful recitation of the eight faculty members and their topics of instruction.[2] The number of MD's awarded annually at the University of Virginia at that time was about 20, an interesting ratio of students to faculty. In 1985 there were 566 members of the full-time faculty in both basic and clinical areas, and each class in the 4-year curriculum had about 140 students.

There were no federal grants and small state support. The first hospital at the University of Virginia opened in 1902. Dr. Mason recalled lectures and laboratory exercises with microscope in the Anatomical Theater, designed by Thomas Jefferson and demolished in 1938 to make way for the Alderman Library. At this time in this medical school the instruction in the preclinical sciences appears to have excelled that in the practical areas: "We were very well trained didactically. Our students were so successful in New York City at Bellevue that almost all of them were given appointments, and a complaint went up. Finally, Bellevue made a rule that the University would be allowed only a certain portion of appointments." After the establishment of a State Board of Medical Examiners for licensing physicians in 1885, "the University had a record of practically no failures."

Dr. Mason's memory of practical instruction suggests lean and informal fare, focused on the Dispensary rather than the new hospital: "Well, when I first went there the hospital consisted of an old brick building directly across the street from the Dispensary Building." (These buildings were located on both sides of Main Street in approximately the areas of the current University Theater and the George Rogers Clark Monument.) "The Dispensary building had an amphitheater. The patients waited out in the hall and kept warm in the winter by a large pot-bellied stove. Each clinical professor had appointed one of the students as his assistant, who lived in the dispensary and got his room free that way.

"I might mention a picturesque old janitor named Jack Collier, who slept in the building. The Dispensary did not have a sterilizer. When Jack felt like things ought to be a little cleaner he would take a bucket of hot water and pour it over the spigot, and he said, 'There doctor, that kills them all', apparently meaning the source of infections.

"The patients did not stay in the Dispensary overnight. The patients in the hospital across the street were anesthetized and brought over on a stretcher into the amphitheater, where there was an old operating table you might call it, built by a local carpenter. It rotated so that the students could see the operations. The surgeons brought their own instruments with them, already boiled at home and wrapped in a sterile towel. There was little in the way of practicing asepsis. After these operations patients were carried back to the so-called hospital".

"The members of the University faculty and other city doctors did the major operations in the patients' homes in those days, using the kitchen table as an operating table, and apparently they had very good

The operating room in the Dispensary, with rows of seats for student obervers. Note the absence of surgical masks.

results." Although I failed to ask Uncle Norton to specify, it appeared that the dispensary was used more for rural and less prosperous patients.

"No obstetrical patients ever went to hospitals in those days. It was all done at home, and the students at the session on obstetrical teaching were very anxious to have experience. We paid a special black woman one dollar for getting us each a case of obstetrics. The material consisted of going to the drugstore and getting ten cents worth of creolin, and some bought a five-cent nail brush, and the results were very good."

In the 1980s medical education has seen debates about the effectiveness of the clinical faculty, whose primary interest may often be biomedical research, and the need for "role models" has been raised. I asked Uncle Norton whether he thought of his faculty as having been good teaching physicians or surgeons.

"Well, I don't like to go into particulars, " he answered, "but in those days a doctor was not considered a very fine doctor unless he did his own surgery. The doctors who did not operate were looked down on by the general public as not 'finished' doctors, who didn't know how to operate on patients. At the new University Hospital, which was built later on, they did not allow surgeons in the city to operate unless they were teaching at the hospital."

"Some of the city doctors were good teachers, especially Dr. Magruder. He was a very good teacher on physical examinations, and in fact he wrote a book about it. Dr. Browning was a very good surgeon. During my third year in medicine Dr. Charles Venable of Charlottesville, whose father was a professor at the University, gave me a position as his assistant. I had an opportunity to go around with the men around the city. I lived in Dr. Venable's home and used his father's old office for a bedroom. Dr. Venable decided that he and Dr. Browning would go North for two or three weeks to study. He said, 'Now you are entirely in charge of my practice while I am gone.' I had not even studied the practice of medicine then, but I told him I would do the best that I could. The few patients that came in, I would talk to them and examine them a little, and then get out Squibb's *Materia Medica*. It is full of prescriptions, and I would find the page with the name of the disease and copy a prescription. I don't know whether I did any good, but I don't think I killed anybody."

THE HIGH IMAGE of surgery reflected in Dr. Mason's comment was, as we now know, shared increasingly by society in our time. Surgeons had been on a long climb from a primary affiliation with barbers in the 17th century, and the 20th century has seen remuneration patterns and even excessive procedures as targets for reform. The curriculum committees of today are realizing that entirely hospital-based teaching gives students a distorted emphasis on severe illness and intensive use of technologies. They plan to put students more in "ambulatory care settings" and perhaps again use the resources of volunteer faculty. Dr. Mason's experience may give hope to those attempting this difficult change. Delegation of responsibility, such as Dr. Venable could give

his student assistant, and considered invaluable for student learning, is riskier when medicine's power both to help and to harm are much greater.

In 1904 there was almost no support for postgraduate training, which was recognized then as especially important for graduates of a school in a rural area without a substantial hospital. Accordingly, it was important to gain practical experience by spending a year or two in an urban area where population density and disease frequency gave better chances at observation and responsibility. Dr. Mason noted that after medical school he "had no money", and he first took a position at Central State Hospital in Petersburg, primarily a custodial institution for the mentally ill.

"Then I went to St. Luke's Hospital in New York for the summer until I got a position on Randall's Island at the hospital for children, which was owned by the city. By the way, on this island were 2,500 employees, and most of them had been run out of the city courts, the judge saying, 'You can go to jail or you can to go Randall's Island and work for ten dollars a month.' There were all sorts of hospitals and dispensaries in New York. I was always eager to get some practical training in studying patients. Dr. Berkely, a native of Staunton, ran a course of one month at the Good Samaritan Hospital down in the slums. Nobody spoke English, but he was a very good teacher, and I got a great deal of information from him.

"Most hospitals had their own ambulances. They were all horse-drawn, and they were open in front and back. No front windows or back doors, and in zero weather the zero weather blew right through. At the New York Infant Asylum, where I spent most of my residency, the health department rule was that any child who developed a contagious disease was sent up the river to another city hospital. Many of them died up at what was called the Riverside Hospital, which was a pretty bad situation.

"There was a great deal of diphtheria of the larynx, called membranous croup. There was a hospital called the Willard Parker Public Hospital, and they had two ambulances, and they carried the instrument called intubation. The hospital would get these hurry "croup calls," and they would be there in a very short time. The intern and the driver would rush up to the room and put the baby on the kitchen table, and intubation would be done in a few seconds."

Uncle Norton returned to Richmond to start an independent practice of general medicine and pediatrics in 1907. He started a pediatric clinic at the Medical College of Virginia for indigent patients. His office was the front room of his home, a handsome brick house (since demolished) at the corner of Lombardy and Grace Streets. The waiting room was the house's front hall, and I remember passing through the waiting room in the 1940s to visit the family, who congregated to the rear and upper floors of the house. In the front hall waiting room would be a row of patients—someone with an abscess to be drained, another with a cough or rash to be treated, an infant in arms with who-knows-what, and a worker with a recent fracture to be set and casted. The nature of these problems were then unknown to me, but the frosted glass pane on Dr. Mason's office-surgery door and the smell of ether made me think something important was happening on the other side. There were no hints of great prosperity in the family—no expensive cars, clothes, hobbies or vacation trips. These amenities may now be taken for granted by the doctors of our time. Then, the opportunity to practice the craft must have meant both burden and satisfaction enough.

The most challenging time was the influenza epidemic of 1918.

"This time they opened up the windows, giving them the fresh air treatment, and an enormous amount of pneumonia occurred from breathing this cold air. The John Marshall High School here was turned into a hospital, and they were brought in alive through the front door and carried out dead through the back door. I went down there and told them to pull down all the windows . . . When I was at the University, Dr. John Staige Davis one day in his lecture stated that there was a specific for influenza, and this was a drug called bicarbonate of potassium, and the dose was 30 grams dissolved in water every two hours . . . During that and many other years afterward I lost practically no patients."

I asked Dr. Mason for a summary of the changes in the medical profession, or the public's perception of us, during his lifetime.

"Doctors were often a friend of the family. As I have mentioned, people would tell their doctors things that they would not tell their minister . . . There were very few hospitals when I started out in 1907. The Memorial Hospital at 12th and Broad was a model, up to date, partly private and partly wards. The rate in the ward was one dollar per day, which included bed, general nursing, meals and medicine. No charge for the operating room or laboratory. Very few people had any money to go to the hospital, they didn't have the dollar a day to pay. The single rooms were twenty-five dollars a week, and a bed in a double room was fifteen dollars a week. The nurses in those days were mostly very fine country girls, many of them daughters of physicians. They had a purpose to dedicate their lives to the profession, and hours were not considered. I think that there was so much dedication in the first part of my life as a doctor, selflessness among nurses and doctors. I don't think that more than 50% of the patients that I had were paying patients. The doctors treated all those that didn't have money free of charge."

"Did people try to take advantage of you?"

"No, not at all."

THESE RECOLLECTIONS probably contain minor errors in facts, and our main task is to decide the reality of the interpretive comments. American medicine has been described recently as coming more from an entrepreneurial than a service tradition; the commentators and participants of two generations ago seem to have recognized some elements of a service tradition now less visible. We live in a time of greater cultural diversity, greater confidence in technology and the therapeutic paradigm, less durable affinities among persons and less discrete roles of institutions, greater material rewards, and possibly fewer psychological rewards among the medical profession.

Much of the 20th century thought in the West has been dominated by a therapeutic or educational paradigm—the solving of problems by technological or instructional interventions. Disenchantment with this recently may be occurring, and may be in part a realistic perception of our limits. Nevertheless, the therapeutic paradigm based on biomedical science and properly applied, deserves to endure. Its exploitation either for personal gain or in ignorance of its limits will weaken it. If the students of recent years have shown an entrepreneurial focus or preoccupation with the therapeutic paradigm, perhaps substitution in the curriculum of history and literature would broaden their vision. Along with the current emphasis on "problem-solving skill," there should perhaps be some cultivation of concept development and felicity of communication.

We have heard both ominous portents and hopeful initiatives from medical educators. Dr. Mason's case report, roughly congruent with many other observations from and about his time, may give clues to some of the directions, where an advance may be, without apology, the same as a recovery.

LOCKHART B. MCGUIRE, MD

[1] Paul Starr, The Social Transformation of American Medicine, 1982

[2] Listed by Dr. Mason were Dr. Buckmaster, professor of Obstetrics/Gynecology; Dr. Paul Barringer, professor of physiology and materia medica; Dr. John Staige Davis, professor of the practice of medicine; professor of chemistry John W. Mallet; Dr. William G. Christian, professor of anatomy and surgery; Dr. Albert Tuttle, professor of biology; and assistants Dr. James B. Bullitt and Dr. Carroll Flippen. The University of Virginia catalog for 1904 lists in addition to these full-time faculty six part-time clinical faculty members, several of whom are described in this interview. There were 30 doctorates in medicine awarded in 1904.

A complete transcript of Dr. McGuire's interview with Dr. Mason appeared in the Winter 1976 edition of the *University of Virginia Medical Alumnews*.

Address correspondence to Dr. McGuire at Box 158, University of Virginia Health Sciences Center, Charlottesville VA 22908.

MEDICAL SOCIETY OF VIRGINIA

President
William H. Barney, MD, Lynchburg
President Elect
John A. Owen, Jr., MD, Charlottesville
Immediate Past President
J. Thomas Hulvey, MD, Abingdon
First Vice President
Leon I. Block, MD, Falls Church
Second Vice President
William W. Regan, MD, Richmond
Third Vice President
William H. Sipe, MD, Newport News
Speaker
George E. Broman, MD, Culpeper
Vice Speaker
Lawrence K. Monahan, MD, Roanoke

Councilors by District
1st: **Louis D. Parham, MD,** Hampton
2nd: **Russell D. Evett, MD,** Norfolk
3rd: **James A. Shield, Jr., MD,** Richmond
4th: **John W. Hollowell, MD,** Portsmouth
5th: **Edwin J. Harvie, Jr., MD,** Danville
6th: **Jeffrey W. Wilson, MD,** Lynchburg
7th: **H. George White, Jr., MD,** Winchester
8th: **Ira J. Green, MD,** Alexandria
9th: **James L. Patterson, Jr., MD,** Pulaski
10th: **Ira D. Godwin, MD,** Fairfax

AMA Delegates
H. C. Alexander III, MD, Roanoke
Raymond S. Brown, MD, Gloucester
Charles M. Caravati, Jr., MD, Richmond
C. Barrie Cook, MD, Falls Chruch
Richard L. Fields, MD, Fairfax
William J. Hagood, Jr., MD, Clover
John A. Martin, MD, Roanoke
Harold L. Williams, MD, Newport News
Percy Wootton, MD, Richmond

Executive Vice President
James L. Moore. Jr.

OBITUARY

• **Robert B. Neu, MD,** Arlington psychiatrist; Georgetown School of Medicine, 1942; age 69; died March 16, 1990. A past president of the Arlington Medical Society, he had been Speaker of the Assembly of the American Psychiatric Association.

• **Raymond Schwartz, MD,** longtime Falls Church internist; Cornell University School of Medicine, 1937; age 76; died March 24, 1990. He had been chief of the health services division of the Arlington Department of Human Resources.

Memoir of Frank Sloop 1947-1989

By Stephen E. Schmitz, MD

Frank B. Sloop, Jr., MD, died on August 10, 1989, at the age of 42.

Born in Salisbury, North Carolina, he studied at the University of North Carolina at Chapel Hill where he received a BA in English and a doctor of medicine degree in 1973. He continued his postgraduate medical training at the University of Virginia Medical Center, where he was a resident in pathology 1973–1977.

Dr. Sloop became the first director of anatomic and clinical pathology at the Martha Jefferson Hospital in Charlottesville, Virginia, in 1977. He served in this capacity until his untimely death. His dedication to developing and expanding laboratory services at the Martha Jefferson Hospital was never-ending. His energy and resourcefulness were quickly recognized and he served the hospital in many capacities, including numerous committees and, ultimately, membership in the Health Service Corporation board of trustees and Foundation board of trustees.

Frank was a member of all the major pathology societies, the AMA, and the Albemarle County Medical Society. Through the years he was a recipient of many awards, including the Morehead Award at the University of North Carolina in 1965; Phi Beta Kappa in 1969, several undergraduate honor societies, and Alpha Omega Alpha.

In addition to his mother, Mrs. Gladys Eudy Sloop, Dr. Sloop is survived by his wife, Anne Dye Sloop; a daughter, Katherine Anne Sloop; two sons, Mark David Sloop and Peter Daniel Sloop, all of Charlottesville; a sister, Linda Sloop Nunalee of Wilmington, North Carolina; and a brother, David Arthur Sloop of Raleigh, North Carolina.

Frank is deeply missed by his family, medical colleagues and many friends. His expertise extended far beyond medicine and he was equally respected with a golf club in hand. He accomplished much in a short time and managed to keep all those around him smiling with his quick wit. All who knew Frank B. Sloop, Jr., have suffered a great loss.

Memoir of E. N. Weaver 1917-1989

By Charles B. Bray, Jr., and Robert S. Hutcheson, MD

Edgar Newman Weaver died in Roanoke, Virginia on August 14, 1989, at the age of 71. He was a true Virginian, born in Orange County on November 13, 1917, the son of Dr. and Mrs. Delmar Franklin Weaver. He attended Hampden-Sydney College and graduated from the University of Virginia School of Medicine in 1943. He served two years in the Navy as chief of neurological surgery at the Bethesda Naval Hospital. After his naval service he returned to his beloved University as clinical professor of neurosurgery, where he remained until starting private practice in Roanoke in 1950. He remained closely associated with the Department of Neurological Surgery while maintaining an active private practice.

He contributions to the field of Neurosurgery were many. He served as chief of neurological surgery and of the neurosurgery intensive care unit at the Roanoke Memorial Hospital for a number of years. He was a member of the board of trustees of Jefferson Hospital and active as consultant at the Veterans Administration Hospital in Salem and the Community Hospital of Roanoke Valley. He was co-founder of the Congress of Neurological Surgery and a member of the Harvey Cushing Society. He was a founding member and former president of the Neurological Society of Virginia. He was a member of the Roanoke Academy of Medicine, The Medical Society of Virginia, and the AMA. He was a fellow of the American College of Surgeons and a diplomate of the American Board of Neurological Surgery and was also a frequent contributor to the Neurosurgery literature. He was a charter member of the Advisory Committee of the University of Virginia School of Medicine, later serving as president. He was a member of the board and president of the University of Virginia Medical Foundation and a member of the White-Burkett Miller Center. For the past six years he was a devoted member of the University of Virginia Board of Visitors and served untiringly from 1983 until his death. He was a member of St. John's Episcopal Church and had served as a vestryman.

He is survived by his wife, Evelyn Richards

Weaver, Roanoke; one son, Dr. Edgar Newman Weaver, Jr., Roanoke; two daughters, Mrs. Margaret Weaver Crosson, Roanoke, and Mrs. Dabney Weaver Dwyer, Dallas, Texas; one brother, two sisters and eight grandchildren. He was preceded in death by his son, Dr. David Delmar Weaver, a neurosurgeon in Dallas, Texas.

Dr. Weaver was a master diagnostician, a gifted surgeon and a caring physician. His family, his host of friends and his patients knew his extraordinary sensitivity and the gentleness of his nature. So many dimensions of his life set high standards for the rest of us and each one of us will treasure our memories of Tuffy and the ways he touched our lives.

Memoir of William Foster 1922-1989

By Andrew A. Slemp, MD

William Leicester Foster, MD, of Roanoke, a practicing physician of family medicine, died on June 27, 1989, at the age of 67.

Dr. Foster was born in Asheville, North Carolina, and attended Johns Hopkins University and the University of North Carolina. He was an honor graduate of the University of Maryland School of Medicine in 1945, being ranked number two in his class. After serving in the Army Medical Corps for three and one-half years, he joined the Melrose Clinic in Roanoke in 1948 and practiced family medicine there for 40 years. This devoted physician whose life was truly one of service, said, while ill, "I have no regrets, for I did my best and if given the opportunity, I would do the same again." He felt so fortunate and proud to be on the staff of such an outstanding hospital as Roanoke Memorial for all those 40 years.

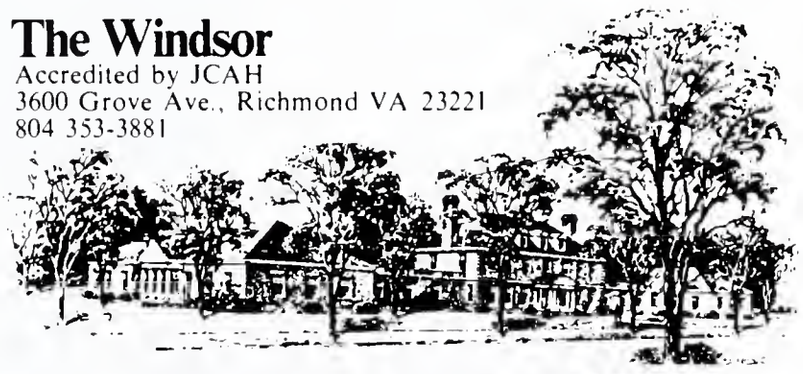
Bill married his wife Jay in 1946, and their children, William L. Foster, Jr., MD, of Raleigh, North Carolina, and L. Annette Foster, of Durham, North Carolina, brought him much happiness. He was proud of his family and their accomplishments.

Bill will long be remembered by his many friends as an avid reader, especially interested in business and history. His real relaxation was boating at Claytor Lake, and some of his happiest times were spent with his grandsons, Mark, Scott and David.

For all his years of dedicated service, he will be remembered fondly by his patients, colleagues, and friends in the community. He was a good friend, devoted to the practice of medicine and to his family.

LONG-TERM CARE: IN SIXTH DECADE OF EXCELLENCE

The Windsor
Accredited by JCAH
3600 Grove Ave., Richmond VA 23221
804 353-3881



Mrs. Plyler's
Residential Care
1615 Grove Ave., Richmond VA 23220
804 353-3981

University Park
Accredited by JCAH
2420 Pemberton Rd., Richmond VA 23233
804 747-9200

VIRGINIA MEDICAL CLASSIFIED

Virginia Medical classified ads accepted at the discretion of the Editor. Rates to Medical Society of Virginia members: $15 per insertion up to 50 words, 25¢ each additional word. To non-members: $30 per insertion up to 50 words, 25¢ each additional word. Deadline: 5th day of month prior to month of publication. Send to the Advertising Manager, 4205 Dover Road, Richmond VA 23221.

SOUTHWESTERN Virginia—Busy physician looking for associate. Modern Clinic 15 minutes from 100-bed hospital. Present physician looking to retirement in one to two years. Phone 703-728-2401 Days; 703-728-7231 Nights.

FOR SALE—Solo family practice in Northern Virginia just inside the Washington D.C. beltway in rapidly growing Fairfax County. Ideal location, excellent income, terms flexible, will stay on for one year to help new owner get organized. Dr. Horn, 4540 John Marr Drive, Annandale VA 22003, (703) 256-6010.

NORFOLK, Virginia—Retiring from 25-year solo practice of general surgery. Excellent opportunity for surgeon to take over office, records and equipment. Prime location in well-established shopping center. Call 804-588-4619.

UNSECURED LOANS for physicians. Call Dr. Gerald Sacks, 703-751-3226.

NORTH CAROLINA Outer Banks—Almost one acre semi-oceanfront ocean-view lot ready for building. Northern Outer Banks exclusive Spindrift community. Mr. Bob Cessna, 919-261-3566.

FARMVILLE, Virginia—Seeking full-time and part-time physicians for hospital located 1 hour west of Richmond. Excellent compensation, full malpractice insurance coverage, and benefit package to full-time staff. Contact: Betty Albrecht, Emergency Consultants, Inc., 2240 S. Airport Road, Room 40, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

NORTHWESTERN PA—85-bed hospital in rural Northwestern Pennsylvania seeking additional orthopedic surgeon for rapidly growing practice. Salary of $130,000, malpractice, other benefits. Call: Wanda Parker at 1-800-221-4762, or collect, 212-599-6200. E. G. Todd Associates, 535 Fifth Avenue, New York, NY 10017.

HOLTER RECORDERS provided to physician's offices at no charge. Virginia Heart Institute's services includes scanning, analysis and interpretation of Holter 24-hour ambulatory recordings. Call 804-359-9265 or in Virginia 1-800-468-1030.

FAMILY PRACTICE on Chesapeake Bay—Owner retiring. Start enjoying medicine again. Four day work week, no HMO, PPO, or Medicaid. Join owner and take over practice in one to two years. Send reply to Va Med Box 133, 4205 Dover Road, Richmond VA 23221.

FAMILY PRACTICE—Pennsylvania practice-solo, with 4 other Family Practitioners for call. Cash collected first-year minimum income guarantee of $85,000, first 6 months office overhead fully paid. 104-bed hospital, 43,000 annual admissions, 37-member staff. Call: Wanda Parker at 1-800-221-4762, or collect, 212-599-6200. E. G. Todd Associates, 535 Fifth Avenue, New York, NY 10017.

PHYSICIANS WANTED—Family physician or internist for office and hospital practice in the greater Richmond area. There is also an opening for a semi-retired physician for part-time work. Inquiries held strictly confidential. Send CV and financial requirements to Va Med Box 131, 4205 Dover Road, Richmond VA 23221.

SURGEON—85-bed hospital in rural Northwestern Pennsylvania seeking additional general surgeon. Salary of $100,000, office overhead, malpractice, other benefits. Call: Wanda Parker at 1-800-221-4762, or collect, 212-599-6200. E. G. Todd Associates, 535 Fifth Avenue, New York, NY 10017.

WASHINGTON DC—Internist BC/BE to join young, busy internist in Virginia suburbs of Washington DC. Strong commitment to primary care required. Excellent salary, benefits and partnership pathway. Send CV and cover letter to VA Med Box 132, 4205 Dover Road, Richmond, VA 23221.

PEDIATRICIAN—85-bed hospital in rural Northwestern Pennsylvania seeking additional Pediatrician. Salary of $75,000, office overhead, malpractice, other benefits. Call: Wanda Parker at 1-800-221-4762, or collect 212-599-6200. E. G. Todd Associates, 535 Fifth Avenue, New York, NY 10017.

POSITIONS AVAILABLE in Virginia Beach and surrounding cities—Sentara Medical Care Centers, a subsidiary of Sentara Health Systems, Virginia's premier health care network, are seeking BC/BE physicians to staff its Centers. Family practice opportunities also available. Flexible hours, competitive compensation package, incentive programs available. Excellent recreational, cultural, and educational area. Send CV to Gail Billups, Sentara Medical Care Centers, 22 Koger Executive Center, Suite 202, Norfolk, Virginia 23502 or call collect 804-466-9187. An Equal Opportunity Employer.

CENTRAL PA—177-bed, south central Pennsylvania hospital seeking board certified/eligible emergency physician. 21,000 ED visits/year. Salary of $100,000, 4 weeks vacation, 2 weeks CME. Call: Wanda Parker at 1-800-221-4762, or collect, 212-599-6200. E. G. Todd Associates, 535 Fifth Avenue, New York, NY 10017.

RICHMOND Virginia—B/E Family Practitioner desires office work full-time July and August 1990, Richmond or suburbs. No hospital work. Do you and your partners need vacation coverage? Contact Dr. T. J. Wade, 8408 Bronwood Road, Richmond, Virginia 23229. Telephone 804-270-1687.

continued on page 224

Because safety cannot be taken for granted in H_2-antagonist therapy

AXID®
nizatidine

Minimal potential for drug interactions

Unlike cimetidine and ranitidine,[1] Axid does not inhibit the cytochrome P-450 metabolizing enzyme system.[2]

Swift and effective H_2-antagonist therapy

- *Most patients experience pain relief with the first dose[3]*
- *Heals duodenal ulcer rapidly and effectively[4,5]*
- *Dosage for adults with active duodenal ulcer is 300 mg once nightly (150 mg b.i.d. is also available)*

References

1. USP DI Update, September/October 1988, p 120.
2. Br J Clin Pharmacol 1985;20:710-713.
3. Data on file, Lilly Research Laboratories.
4. Scand J Gastroenterol 1987;22(suppl 136):61-70.
5. Am J Gastroenterol 1989;84:769-774.

AXID®
nizatidine capsules

Brief Summary. Consult the package literature for complete information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to eight weeks of treatment. Most patients heal within four weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than one year are not known.

Contraindication: Known hypersensitivity to the drug. Use with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H_2-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

PV 2098 AMP [091289]

Additional information available to the profession on request.

Lilly **Eli Lilly and Company**
Indianapolis, Indiana
46285

NZ-2924-B-049310 ©1990, ELI LILLY AND COMPANY

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

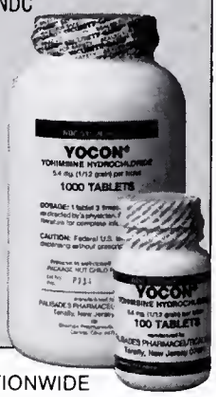
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

PALISADES PHARMACEUTICALS, INC.
219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

AVAILABLE—Cardiologist: American born/trained; 42; board-certified; experienced in PTCA, cath, echo/Doppler, critical care, clinical skills; Master's degree in Education; seeking private or institutional position in/near metropolitan area in VA. Please contact Raymond Vergne, MD 1000 Grandview Ave, Pittsburgh PA 15211; 412-621-4179 office, 412-431-0977 evenings.

FOR SALE—General Electric Maximar 100 for superficial therapy with all filters and cones and rail for mounting. In excellent condition. Call Allen Peple, MD, 804-648-1052 (Richmond).

WESTERN NY—102-bed hospital in Western New York, offering cash collected first-year minimum income of $80,000, 6 months office overhead, and malpractice. OB/GYNs provide subspecialty backup. Possible University affiliation. Call: Wanda Parker at 1-800-221-4762, or collect 212-599-6200. E. G. Todd Associates, 535 Fifth Avenue, New York, NY 10017.

FOR SALE—Used medical equipment, almost like new. 1) EKG machine, automatic, single channel, Burdick, used 10 months, originally $2148, now $1300. 2) Three wall-mounted Welch-Allen otoscope/ophthalmoscope combinations with transformers, originally $1175, asking $250 for each unit or $750 total. Call 804-355-7353 (Richmond).

APPRAISALS & SALES—The specialists in on-site practice valuations and transfers to physicians, hospitals and investors. Please contact: Ed Strogen, Fulton, Longshore & Associates, Inc., 527 Plymouth Road, Suite 410, Plymouth Meeting PA 19462; 215-834-6780 or 1-800-346-8397.

MEDICAL OFFICE for rent—West Springfield, Va. Professional park in upper middle-class community of Fairfax County. 950 square feet. Three exam rooms, reception office, business office, lab, bath. On hall with 4 other doctors. Ideal for any practice. No CPI increase $1070/month lease. Call Dr. Robert DeAngelis, 703-451-8777, for details.

WINTERGREEN RENTAL—Cliffs Condominiums, two bedroom, two bath, overlooking entire Wintergreen village near top of the expert slope. Rates are substantially less than through Wintergreen's front desk. Call Thomas Shuttleworth at 804-431-3100 or write 2809 S. Lynnhaven Road, Virginia Beach VA 23452.

OCEANFRONT COMPLEX on Topsail Island, NC—Second row 3-bedroom, 2½-bath with oceanview. Fully equipped. Pool. Sleeps 8. On/off season rentals. Paul & Susan Levine, 804-973-4732.

SANDERLING SALE, Duck, N.C.—Beach cottage by owner. 4/5 bedrooms, 2½ baths, less than fifty yards from ocean across boardwalk, excellent rental history, $325,000, financing available. 804-794-7600 (W), 804-794-9061 or 804-272-6240 (H).

TWO-STORY HOME—Beautifully restored two-story home situated on 2.2 acres overlooking Nomini Creek, 8 feet depth at end of pier, wild life park on opposite shore, large trees surround home, 4 bedrooms, 2½ baths, large dressing room in master bedroom, 35×14 living room, 23×14 dining room, slate entrance foyer, beautiful pine paneling with exposed beams, sun porch and sun room. Guest cottage and outdoor brick grill. Priced $25,000 below value. Contact J. Shapiro, MD, 703-752-4480.

FAMILY PRACTICE. A REWARDING EXPERIENCE IN ARMY MEDICINE.

The Army has more soldiers with families than ever before. So when you join the Army Medical Team as a Family Practitioner, expect to spend most of your time serving not only soldiers, but their spouses and children, too. What's more, you won't have to worry about the paperwork, malpractice insurance premiums, or the costs incurred in running a private practice.

Expect to work in a highly challenging and varied environment. Working with a team of highly trained professionals, you can receive assignments almost anywhere in the United States; the Army offers the largest system of comprehensive health care in the nation. Family Practice positions are also available overseas, in Germany and Korea.

The benefits package available to Army Family Practitioners is quite attractive. You'll receive 30 days paid vacation, opportunities to continue education and conduct research, a chance to travel, and reasonable work hours.

All in all, your Army Family Practice will be a rewarding experience. Not only for you, but for Army families, too. Talk to your Army Medical Department Counselor for more information.

ARMY HEALTH CARE TEAM
Federal Office Building
400 North 8th Street
PO Box 10167
Richmond VA 23240-0167
(804) 771-2354

ARMY MEDICINE. BE ALL YOU CAN BE.

Sometimes. . .even the clearest label needs another label.

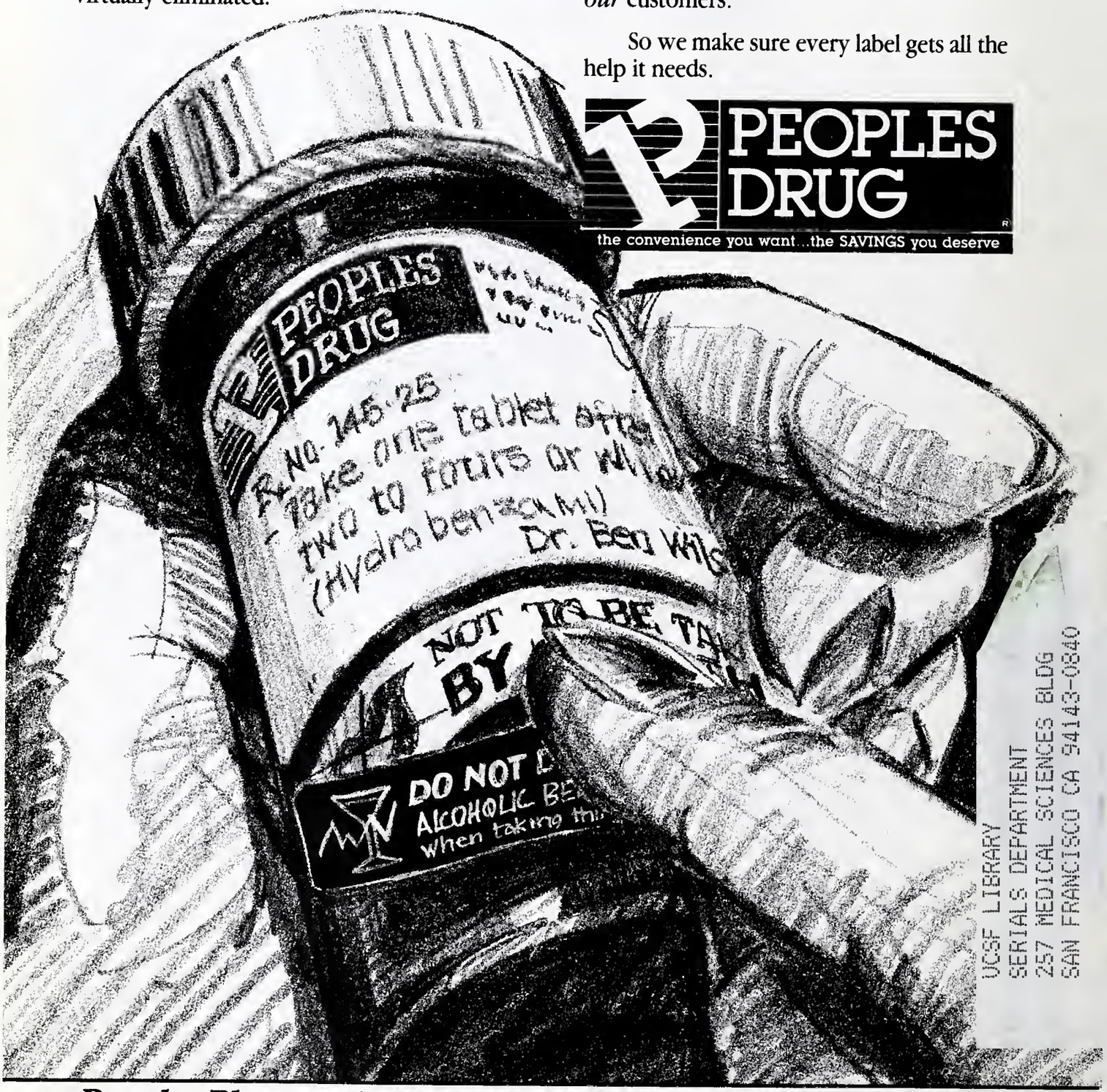
When we label our prescriptions, we cover all the bases. Our comprehensive system of auxiliary labels highlights your prescription orders clearly and simply so your patients get the full benefit of their medications. Misuse and the danger of possible side effects are virtually eliminated.

It's just another example of how—for over 80 years—Peoples Drug has served its customers with unmatched care and professionalism. Today, all our services reflect our continuing commitment to meeting the changing needs of *your* patients. . . who become *our* customers.

So we make sure every label gets all the help it needs.

PEOPLES DRUG®

the convenience you want...the SAVINGS you deserve



UCSF LIBRARY
SERIALS DEPARTMENT
257 MEDICAL SCIENCES BLDG
SAN FRANCISCO CA 94143-0840

Peoples Pharmacists. Working with you to help your patients.

CURRENT
JNLS
W1
VI
799J

Virginia Medical
UCSF LIBRARY
Received on: 06-20-90

VIRGINIA MEDICAL

The Award Winning Pu Medical Society of Virginia

The Auxiliary and the Teen-Ager

ne 1990
lume 117, Number 6

ANESTHESIOLOGISTS: BROADEN YOUR EXPERIENCE.

Your time and talent are valuable. They're valuable to the Army Reserve, too. We'll pay you for a small fraction of your time, not only in money, but with big opportunities and challenges you won't find in civilian practice.

- You'll have flexibility in how and when you participate.
- You'll be offered conferences and continuing education.
- You'll have opportunities for military training in areas like Advanced Trauma Life Support, Parachuting, Flight Medicine and Mountaineering.
- You'll work with top, dedicated professionals.
- You'll have the rank and privileges of an Army officer.

If you want more information about the Army Reserve, or if you would like to talk to an Army Reserve physician, our experienced Army Reserve Medical Counselors can assist you. Call collect or write:

Major Wayne S. Young
P. O. Box 10165
Richmond, Virginia 23240-0165
804-771-2401

BE ALL YOU CAN BE.®

ARMY RESERVE

Why buy an office automation system that doesn't offer a long-term solution?

ACCLAIM™ from Sentient is the total system solution.

A lot of medical practices are planning to invest in an office automation system. But a lot of the systems out there just don't offer the comprehensive functions and long-term expandability that your practice may need.

IBM® and compatible hardware.

The ACCLAIM system operates on IBM and compatible hardware, so you know you're getting the quality standard of the industry. And it's completely expandable, so it can grow as your practice grows.

Long-term support.

ACCLAIM is the system solution that fits your needs today. And Sentient's software engineers, customer trainers, and telephone support people are always there to make sure your system fits your needs over the years to come.

Easy to operate.

Even if your staff has no previous computer experience, ACCLAIM is simple to operate effectively and efficiently. Complete training is included in the purchase.

When you're thinking about office automation, call Sentient first, and find out what ACCLAIM can do for you.

1-800-247-9419
(In the D.C. Metro area call 1-301-929-7600.)

SENTIENT
SYSTEMS

We set the standard in medical computing.

VIRGINIA MEDICAL

June 1990, Volume 117, Number 6

© 1990—The Medical Society of Virginia

SPECIAL REPORTS

233 **Reforming the Tort:** Injured Infant Act Changes; Bulala Case and the Cap

234 **No Dumping Allowed:** New Rules for Patient Transfer

246 **The Auxiliary and the Teen-Ager:** Notes and photographs from a big production starring healthy behavior

POINT OF VIEW

250 **Legalizing Drugs: a Few Simple Questions** David A. Zohn

MEDICINE

251 **Cocaine: Recognizing, Treating the Abuser** Peter Coleman

255 **20-Year Survival of von Hippel-Landau Hemangiomatosis: Case Report** Leo Goldhammer

259 **Branchial Cysts Presenting as Neck Infections** Michael Mellis, Mary Ann Frable, and David L. Mobley

260 **Abstracts from the Virginia Neurological Society's Annual Meeting**

EDITORIALS

265 **Now a Quarterly** Edwin L. Kendig, Jr.

265 **Thanks for a Super Job** H. C. Alexander III

266 **Collision Course** Bedford H. Berrey

230 **Medical Society of Virginia Officers**

230 **Letters to the Editor** R. Lawrence Smith and Charles L. Baird, Jr.

235 **MSV Phone Book**

241 **Meetings about Medicine**

267 **Obituary**

269 **One Hundred Thirty-Nine New MSV Members**

274 **Classified Advertisements**

278 **Who's Who**

277 **Directory to Advertisers**

Cover photograph by Taylor Dabney

Editor Edwin L. Kendig, Jr., MD

Associate Editors Richard G. Lester, MD; Duncan S. Owen, Jr., MD; John A. Owen, Jr., MD

Editorial Board H. C. Alexander III, MD; Raymond S. Brown, MD; Henry S. Campell, MD; C. Barrie Cook, MD; Eloise C. Haun, MD; Walter Lawrence, Jr., MD; Robert Edgar Mitchell, Jr., MD

Executive Editor Ann Gray Senaida Sayre, Assistant

Business Manager James L. Moore, Jr.

DISCLAIMER: Advertisements in VIRGINIA MEDICAL for products, services, courses and symposia are published with a "buyer beware" understanding. The Publisher, the Editor and members of the Editorial Board do not imply warranty of products, nor endorsement of offered educational material.

VIRGINIA MEDICAL (ISSN 0146-3616) is the monthly publication of The Medical Society of Virginia. Second-class postage paid at Richmond, Virginia. Yearly subscription rate: $24 domestic, $30 foreign; single copies, $3. VIRGINIA MEDICAL does not hold itself responsible for statements made by any contributor. The publisher reserves the right to reject any advertisement. For information on the preparation of articles, write to the Executive Editor for "Advice to Authors," or call (804) 353-2721. POSTMASTER: Send address changes to VIRGINIA MEDICAL, 4205 Dover Road, Richmond VA 23221.

SYMPTOMS: Chronic Cranial Pain Caused by Persistent Reimbursement Confusion and Revenue Erosion

℞: *The Management Company*

Reimbursement Specialists for Over a Decade

Can any **one** person be expected to keep up with complex and rapidly changing reimbursement issues? *Probably not!*

Medical Reimbursement is becoming increasingly complex. That's why **TMC** has over 100 professionals, in 9 offices throughout Virginia, with the expert knowledge you need to maximize your practice revenue.

We have relieved hundreds of physicians and their office staffs of the problems associated with in-house reimbursement systems. With **The Management Company,** you get results quickly. **TMC** clients experience a real increase in practice revenue and control in a matter of months, not years.

We didn't become the leading medical practice management corporation in Virginia by making promises we don't deliver. But don't take our word for it. Call any **TMC** client to find out why we're more than just a "billing" company. We would be glad to provide you with a reference list for your convenience.

Let us take care of all medical billing, coding, collections and reporting. Then you can concentrate on practicing medicine with complete confidence that your practice is managed successfully.

To start reducing your reimbursement anxiety today, call **TMC** for a complete practice analysis, with no obligation. Because if your reimbursement results don't compare to **TMC's** Standards of Performance, you may need expert assistance now.

The Management Company

"Experienced Management for the Practicing Physician"

1-800-262-4862

Don't take our word for it...

Virginia Beach Orthopaedic Associates and
The Sports Medicine and Hand Surgery Center

Robert W. Waddell, M.D.
John L. Dobson, M.D.
Thomas S. Meade, Jr., M.D.
John A. Williamson, M.D.
Colin W. Hamilton, M.D.
Peter C. Jacobson, M.D.
George Raymond Payne, III, M.D.
Patrick W. O'Connell, M.D.

Frank G. Payne, M.D.
(Retired, 1988)

1553 Lila Donaldson Parkway
Virginia Beach, Virginia 23454
Appointments 481-2663

Marlene E. Jones
Administrator

November 8, 1989

Gordon D. McLean
Virginia Insurance Reciprocal
P.O. Box 31394
Richmond, VA 23294

Dear Mr. McLean:

Our office received a most generous refund on our insurance premiums the other day and I wanted to express our group's sincere thanks for it. We certainly welcome the money, and even more so, appreciate the reaffirmation that Virginia Insurance Reciprocal is indeed a company that can be trusted and is not out to "take advantage of subscribers" as is so often depicted in the news media.

This is just a brief note expressing our appreciation to Virginia Insurance Reciprocal and we hope to continue this relationship we have developed over the years.

Sincerely yours,

John A. Williamson, M.D.
John L. Dobson, M.D.
Thomas S. Meade, Jr., M.D.
Colin W. Hamilton, M.D.
Peter C. Jacobson, M.D.
G. Raymond Payne, III, M.D.
Patrick W. O'Connell, M.D.

JAW/slc

Suite 1, Bayside Professional Building, 4501 Witchduck Road, Virginia Beach, Virginia 23455
Appointments 499-3838
Suite 101, Green Run Medical Center Building, 1336 Holland Road, Virginia Beach, Virginia 23456
Appointments 467-0530

[Unsolicited testimonial from one of the many thousands of physicians' groups which received an equity return distribution during 1989.]

Call us … we reciprocate.

The Virginia Insurance Reciprocal

4200 Innslake Drive
Glen Allen, Virginia 23060
Toll free: 1 800 284-TVIR—In Richmond: 747-8600

MEDICAL SOCIETY OF VIRGINIA

President
William H. Barney, MD, Lynchburg
President Elect
John A. Owen, Jr., MD, Charlottesville
Immediate Past President
J. Thomas Hulvey, MD, Abingdon
First Vice President
Leon I. Block, MD, Falls Church
Second Vice President
William W. Regan, MD, Richmond
Third Vice President
William H. Sipe, MD, Newport News
Speaker
George E. Broman, MD, Culpeper
Vice Speaker
Lawrence K. Monahan, MD, Roanoke

Councilors by District
1st: **Louis D. Parham, MD,** Hampton
2nd: **Russell D. Evett, MD,** Norfolk
3rd: **James A. Shield, Jr., MD,** Richmond
4th: **John W. Hollowell, MD,** Portsmouth
5th: **Edwin J. Harvie, Jr., MD,** Danville
6th: **Jeffrey W. Wilson, MD,** Lynchburg
7th: **H. George White, Jr., MD,** Winchester
8th: **Ira J. Green, MD,** Alexandria
9th: **James L. Patterson, Jr., MD,** Pulaski
10th: **Ira D. Godwin, MD,** Fairfax

AMA Delegates
H. C. Alexander III, MD, Roanoke
Raymond S. Brown, MD, Gloucester
Charles M. Caravati, Jr., MD, Richmond
C. Barrie Cook, MD, Falls Chruch
Richard L. Fields, MD, Fairfax
William J. Hagood, Jr., MD, Clover
John A. Martin, MD, Roanoke
Harold L. Williams, MD, Newport News
Percy Wootton, MD, Richmond

Executive Vice President
James L. Moore, Jr.

LETTERS

What info does *your* laboratory's automated CBC count offer?

Drs. Ende[1] and Becker[2] are quite correct when they note that *some* automated CBC equipment will fail to pick up significant eosinophilia, basophilia, or left shift in the granulocytic series. However, *some* automated equipment can pick up these abnormalities, or at least alert the operating technologist by noting abnormalities in the shape of the white cell histogram. The proper followup to such an alert is a manual differential. And *other* equipment actually does a cytochemical, flow cytometric differential count, including eosinophils and basophils. And still *other* equipment can perform differential counts by image analysis of Wright stained blood smears. Rarely are total manual eosinophil counts and peroxidase stains necessary in a screening context.

The important message here is that physicians should know the extent of the information available from the automated CBC done in laboratories they utilize. Such information is easily obtained by calling the laboratory director.

R. Lawrence Smith, MD
Virginia Beach General Hospital
1060 First Colonial Road
Virginia Beach VA 23454

1. Ende M. Automated CBC count may obscure L-tryptophan toxicity diagnosis (letter). Va Med 1990;117:141
2. Becker DM et al. Eosinophilia and myalgia associated with L-trytophan use: case report. Va Med 1990;117:68–70

Encourages reports of complications

Shown below are major complications encountered in patients at the Virginia Heart Institute from March 1973-December 1989. All studies utilized the Sones technique for coronary outpatient arteriography.

Complication	Number	VHI	National (100 Hospitals)
None	1821	97.6	97.0
Vascular	30	1.6	2.0–4.0
Arrhythmia	10	.5	.4
Death	2	.1	.1
Contrast	2	.1	.2
Heart attack	1	.1	.1
Stroke	0	.0	.1
Hemorrhage	0	.0	.1

I would like to encourage other physicians and hospitals to voluntarily list complications of this and other procedures for purposes of quality assurance.

Charles L. Baird, Jr., MD
205 North Hamilton Street
Richmond VA 23221

ANNOUNCING

The NEW Individual Non-Cancellable Disability Program

Endorsed by
Medical Society of Virginia

- **Guaranteed renewable**
- **Level premiums**
- **Long term benefits**
- **Premium discount to MSV members**
- **No group increases**
- **Pays for total and partial disability and/ or loss of income**
- **Liberal underwriting**

ENROLL IN YOUR NEW ASSOCIATION PLAN NOW!

For information call
John P. Pearl & Associates, Ltd.
(804) 282-9600 or 1-800-572-2211 or mail the coupon below

Please send me more information on the MSV endorsed Non-Cancellable Disability Program.

Name _____

Address _____

City _____ State _____ ZIP _____

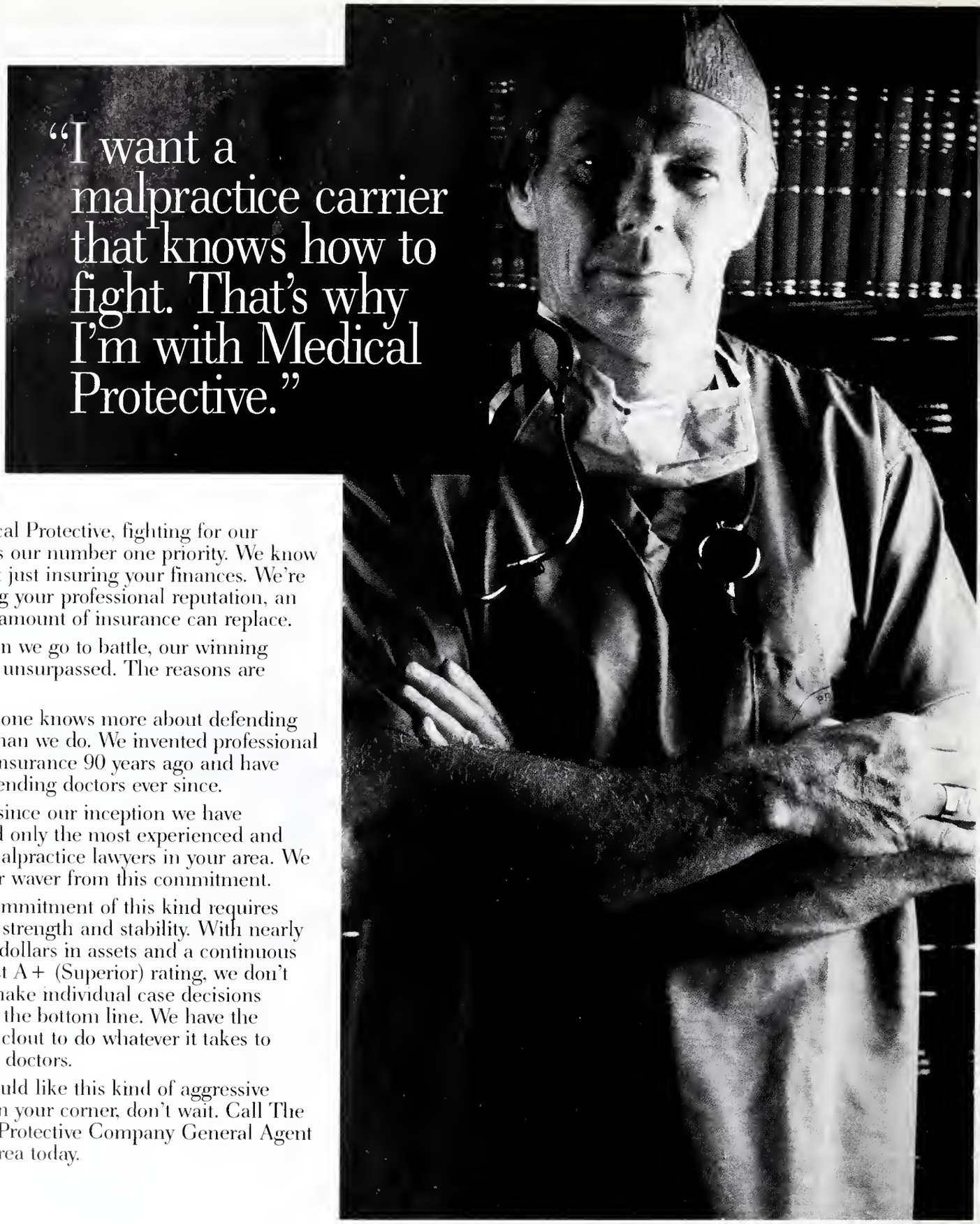
Birthdate _____ Phone _____

Best time to call _____

MSV/900230/3-90

Mail to:

John P. Pearl & Associates, Ltd.
6620 W. Broad St., Suite 300
Richmond, VA 23230-1724



"I want a malpractice carrier that knows how to fight. That's why I'm with Medical Protective."

At Medical Protective, fighting for our doctors is our number one priority. We know we're not just insuring your finances. We're protecting your professional reputation, an asset no amount of insurance can replace.

And when we go to battle, our winning record is unsurpassed. The reasons are simple.

First, no one knows more about defending doctors than we do. We invented professional liability insurance 90 years ago and have been defending doctors ever since.

Second, since our inception we have employed only the most experienced and skilled malpractice lawyers in your area. We will never waver from this commitment.

Third, commitment of this kind requires financial strength and stability. With nearly a billion dollars in assets and a continuous A.M. Best A+ (Superior) rating, we don't have to make individual case decisions based on the bottom line. We have the financial clout to do whatever it takes to serve our doctors.

If you would like this kind of aggressive defense in your corner, don't wait. Call The Medical Protective Company General Agent in your area today.

THE
MEDICAL PROTECTIVE COMPANY

America's premier professional liability insurer.

Ted J. Pandak, David R. Fuller, Suite 205, 7275 Glen Forest Drive, Richmond, Virginia 23226, (804) 285-4131

Reforming the Tort

Injured Infant Act Changes; Bulala Case and the Cap

The following articles appeared originally in the April 1990 edition of The Virginia Section News, *a publication of the American College of Obstetrics and Gynecology and the Virginia Obstetrical and Gynecological Society and are reprinted here by permission.*

THE 1990 Session of the General Assembly passed three bills that amended the Injured Infant Act. One bill redefines a birth-related neurological injury in the manner requested by the Medical Society of Virginia. The amended statute defines such an injury as one that renders the infant permanently "motorically disabled and (i) developmentally disabled or (ii), for infants sufficiently developed to be cognitively evaluated, cognitively disabled. In order to constitute a 'birth-related neurological injury' within the meaning of the Act, such disability shall cause the infant to be permanently in need of assistance in all activities of daily living. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality, degenerative neurological disease, or maternal substance abuse." The revised definition is designed to clarify rather than expand the type of infants protected by the fund and is the product of extensive deliberations by a panel of experts assembled by the Medical Society of Virginia.

The General Assembly also adopted legislation to mandate that the Commissioner of Insurance must require insurance companies writing malpractice insurance in Virginia to include an appropriate discount from the standard premium if the physician is a participating physician under the Injured Infant Act.

Finally, the General Assembly adopted legislation addressing the circumstances under which an injured infant's exclusive remedy is to the Injured Infant Fund. Currently, in order for an injured infant to obtain compensation from the Fund for a birth-related neurological injury, both the physician and the hospital must participate in the Injured Infant Program. If the physician and the hospital are participants, the exclusive remedy available to an injured infant, his personal representatives, parents, dependents or next of kin on account of such injury is to file a claim for compensation under the Act. The injured infant is precluded from bringing a civil suit against the physician or hospital except where there is clear and convincing evidence that the physician or hospital intentionally or willfully caused or intended to cause a birth-related neurological injury and suit on such claim is filed before the award under the Act becomes final and binding.

The amendments to the Act provide that an infant may obtain compensation from the Fund for a birth-related neurological injury if either the physician *or* the hospital is a participant in the Program. The Act, as amended, precludes the infant, his personal representatives, parents, dependents or next of kin from bringing a civil suit against a participating physician or hospital (except in the case of intentionally or willfully caused injuries), but permits the bringing of a civil suit against a nonparticipating physician or hospital as long as no participating physician or hospital is made a party to such suit. However, the commencement of a civil suit against a nonparticipating physician or hospital, regardless of the outcome of the suit, constitutes an election of remedies by the plaintiff and precludes the plaintiff from filing a claim for compensation against the Fund. The amendments also provide that if a claimant elects to file a claim against the Fund and is awarded compensation from the Fund, he loses the right to bring a civil suit against the nonparticipating hospital or physician, but the Fund is subrogated to all of the common law rights based on negligence or malpractice that the claimant had against the nonparticipating physician or hospital.

This portion of the amended Act has two advantages over the current law. First, by electing to participate in the Program a physician can protect himself from civil suits regardless of whether the hospital elects to participate in the Program. Second, severely injured infants are more likely to be protected by the Fund since compensation will be available if either the physician or the hospital is a participant in the Program. A physician or hospital choosing not to participate in the Program remains vulnerable to a civil suit not only by an injured infant but also by the Fund.

All of the foregoing changes become effective on July 1, 1990.

ALLEN C. GOOLSBY, Counsel

ON March 2, 1990, the Virginia Supreme Court released its opinion in the *Bulala v Boyd* case responding to questions of law certified to that Court by the United States Court of Appeals for the Fourth Circuit following the Fourth Circuit's 1989

decision upholding the constitutionality of the Virginia medical malpractice cap on damages. The defendant in this case was an obstetrician/gynecologist who was sued for injuries to an infant, which her mother and her father claimed were created by oxygen deprivation prior to birth.

The case was originally tried to a jury which returned six separate verdicts against Dr. Bulala. These included two verdicts for the child (compensatory damages and punitive damages), two verdicts for the mother (compensatory damages and punitive damages), one verdict for the father (compensatory damages), and one verdict for the father and mother jointly (medical expenses for the child until age 18).

One of the questions certified to the Virginia Supreme Court involved whether, and if so how, the cap is to be applied to multiple plaintiffs and multiple claims by plaintiffs. The Court concluded that the total damages recoverable for injury to a "patient" is limited to the statutory cap, regardless of the number of claims made by that "patient." However, it then decided that, in this case, both mother and the child were to be considered "patients" within the meaning of the Act. The mother was entitled to damages up to the statutory cap for her own physical injury and also her "mental suffering resulting from the birth of a defective child." The Court concluded that at the moment of birth, the child became a "natural person" and a patient of the obstetrician/gynecologist. Accordingly, the child was also entitled to damages up to the statutory cap. In this case, the Court ruled that the father's claim for emotional distress was entirely derivative of the child's claim and was not entitled to a separate statutory cap. Thus in this case, because the child's damages exceeded the statutory cap, the father was not entitled to a recovery.

Another question certified by the Fourth Circuit was whether the statutory cap applies to an award of punitive damages for acts of medical malpractice. The Court ruled that punitive damages are subject to the cap. In this case, no punitives were recoverable since the amount of the statutory cap had already been met.

The Fourth Circuit also certified to the Virginia Supreme Court the question of whether Virginia law allows recovery for the loss of enjoyment of life in a medical malpractice action. The Supreme Court held that "loss of enjoyment of life" would be duplicative since it is already covered by an award of pain and suffering. Thus damages were not recoverable for a separate award of "loss of enjoyment of life."

Justices Russell and Poff dissented from the Court's opinion regarding the application of the term "patient" to the child in this case, under the facts presented. They noted that all of the injuries alleged to the child occurred before she was born. Thus, Justice Russell and Justice Poff considered the child's claims as entirely derivative of the mother's claim. Under this interpretation, all injuries to all three plaintiffs "flow from a single 'injury to . . . a patient,' Dr. Bulala's neglect of Helen Boyd [the mother]," making the total amount recoverable $750,000 (the amount of the medical malpractice cap at the time of this case).

SANDRA L. KRAMER, Counsel

No Dumping Allowed

New Rules for Patient Transfer

Virginia's hospitals are gearing up for the inception on July 1 of new federal strictures relating to the transferring of patients, or, as some would have it, "patient dumping." The new provisions are amendments, passed by Congress last year, to the Consolidated Omnibus Reconciliation Budget Act (COBRA), which was passed by Congress in 1985 and amended previously in 1987.

Since physicians are inextricably involved in patient transfers, Virginia's hospital administrators will be at pains to get fulsome information on the new amendments to their medical staffs. To reinforce those efforts, Va Med offers here, in brief, the salient new provisions relating to physicians. The information is adapted from an article written by Sheila McClanahan, JD, and published in *The Virginia Insurance Reciprocal News* for Jan/Feb 1990.

It should be emphasized first of all that this legislation applies to *all* patient transfers, not just those arising in the emergency room.

The ER setting, however, figures largely in the amendments. For instance, the original statute required medical screenings of a patient presenting to an emergency department in "a medical emergency condition or active labor." As of July 1, 1990, the phrase "or active labor" is out, and *any* patient presenting to an ER must be medically screened to assess whether or not the patient is in a emergency condition.

Note well, however, that the term "emergency condition" is newly defined to include a pregnant woman who is having contractions and 1) there is inadequate time to

effect a safe transfer before delivery and/or 2) a transfer would pose a threat to the health and safety of the woman or her unborn child.

Notable also is the new stipulation prohibiting hospitals from delaying appropriate medical screening and treatment in order to inquire about a patient's method of payment or insurance status.

Generally, the transfer of unstable patients has been forbidden under the Act but with certain exceptions, and the amendments expand on those exceptions, as follows: An unstable patient may be transferred after informing the patient (or one acting on behalf of the patient) of the hospital's obligations and the risks of transfer, and after obtaining the individual's written request for transfer, accompanied by a certification contemporaneously signed by a physician that the medical benefits reasonably expected at another medical facility outweigh the risk to the patient (and, in the case of labor, to the unborn child) as a result of the transfer, or a signed certification by a qualified medical person in a physician's absence. This person must consult with a physician and certify the transfer at the direction of the consulting physician, who must co-sign the document. Note: "Qualified medical person" is not defined by the regulations.

What if a physician refuses to transfer a patient with an unstable emergency medical condition? As of July 1, 1990, the amendments absolve the refusing physician from any penalty, nor may the hospital take any adverse action against the physician for this refusal.

Also expanded under the new amendments is the content of the medical record that must accompany the transferring patient to the receiving facility. It must now include all of the following: records related to patient's emergency room condition; observations of signs/symptoms; preliminary diagnosis; treatment provided; results of any tests; the informed written consent or certification (including the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment).

The amendments define the "responsible physician" subject to the Act's penalties. He or she is "one employed by, or under contract with, the participating hospital and acting as an employee or under such contract, having professional responsibility for the provision of examination or treatment for the individual or transfer of the individual." This physician is subject to a civil fine of not more than $50,000 per violation and/or temporary or permanent suspension of his/her Medicare providers agreement.

Also subject to these penalties as of July 1, 1990, will be a physician who is "responsible for the examination, treatment, or transfer of an individual in the participating hospital, including the physician on call, who knowingly violates a requirement of COBRA, and/or 1) signs a certification when the physician knew or should have known that the benefits did not outweigh the risks; or 2) misrepresents an individual's condition or other information, including a hospital's obligation under the Act."

Rendered immune from the penalties, however, is the initial treating physician who determines that the patient requires the services of one of the hospital's on-call physicians and who so notifies the on-call physician, but the on-call physician fails or refuses to respond "within a reasonable time." In these circumstances, the initial treating physician may order a transfer without incurring a civil penalty or fine. The hospital and/or the dilatory on-call physician, however, may be in trouble.

MSV Phone Book

The Medical Society of Virginia
804-353-2721

American Medical Association
312-645-5000

Virginia State Board of Medicine
804-662-9908

Virginia Department of Health
804-786-3561

Medical Society of Virginia Impaired Physicians Program
804-353-2721

Medical Society of Virginia Review Organization
Preadmission: 800-533-1745;
Richmond 289-5336
General info: 804-289-5320

BC/BS Virginia Physicians Plan
800-552-2103
Richmond 355-8521

John P. Pearl & Associates
800-572-2211
Richmond 282-8900

Dodson Insurance Group
800-825-3760/-3765

Medical Protective Company
804-359-0036

Joint Underwriting Association
804-285-4131

Medicaid Provider Relations
800-552-8627
Richmond 786-6273

Medicare Provider Relations
Pars 804-330-6228
Nonpars 804-330-6237

AIDS Hotline
800-533-4148
Richmond 355-AIDS

The Dual Diagnosis Treatment Program of Sheppard Pratt

Patients with psychiatric illness and drug or alcohol problems present complex diagnostic and treatment challenges.

Sheppard Pratt's inpatient units are designed and staffed specifically for the treatment of these complicated patients.

We provide:

- ☐ Comprehensive psychiatric and chemical dependence evaluation;
- ☐ Specialized programs for patients with affective disorders, anxiety disorders, schizophrenia and learning disorders;
- ☐ Psychopharmacological evaluation and treatment;
- ☐ Specialized programming for the gerontological patient who is chemically dependent;
- ☐ Addiction education for the psychiatric patient who is resistant to treatment for chemical dependence; and
- ☐ On site Double Trouble, AA and NA meetings.

Founded in 1853, Sheppard Pratt is a 322-bed private, not-for-profit psychiatric hospital that provides comprehensive diagnostic and treatment services for short, intermediate or long term patients as well as outpatient and partial hospitalization care.

For more information about Sheppard Pratt's approach to the dually diagnosed patient, or to make a referral, contact the Adult Admissions Office at:

(301) 938-3800
6501 North Charles Street
Baltimore, Maryland 21285-5815

Sheppard Pratt
A not-for-profit health system

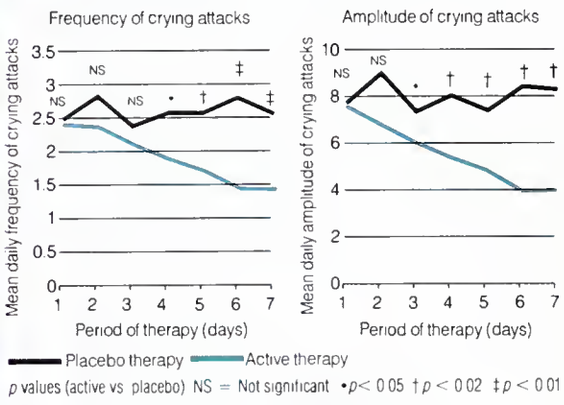
Family therapy for colic.

The excessive crying of colic puts a strain on the most loving family—and often on their physician as well. And whatever the cause of colic, one fact is clear:

Gas is often part of the colic problem.

New Phazyme Drops contains simethicone, which can safely break up gas and bring baby relief. That's why it can help whenever colic is a problem.

Significantly reduces crying of colicky infants.[1]



p values (active vs placebo) NS = Not significant •$p < 0.05$ †$p < 0.02$ ‡$p < 0.01$

Double-blind, randomized, placebo-controlled study

Priced 25% below the leading brand.

This significant price advantage will be particularly important to parents, since they may be relying on Phazyme Drops for up to three months. And it's naturally flavored—something else they'll appreciate.

NEW

Phazyme® Drops (simethicone/antigas)

Helps you through the colic phase.

1. Kanwaljit SS, Jasbir KS. Simethicone in the management of infant colic. *Practitioner.* 1988;232:508.

REED & CARNRICK
Piscataway, NJ 08855

©1989 Reed & Carnrick

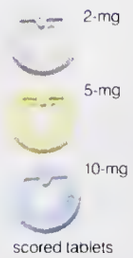
PZ24

The practice is yours.
The patients are yours.
The prescriptions are yours.

Make the prescribing decision yours, too.

Sign on the right on
the "Dispense as written" line.

Specify VALIUM® brand of diazepam/Roche®



The cut out "V" design is a registered trademark of Roche Products Inc.

The one you know best.

Copyright © 1988 by Roche Products Inc
All rights reserved

ROCHE Roche Products

Roche Products Inc
Manati, Puerto Rico 00701

Dr. Holwick outside of hospital where she practices as a civilian traumatologist.

Dr. Holwick in operating room at Letterman Army Medical Center.

JANN L. HOLWICK, M.D.

General and Trauma Surgeon.
Captain, U.S. Army Reserve.

EDUCATION University of Southern California, B.S.; University of California School of Medicine.

RESIDENCY Harbor General Hospital—UCLA Medical Center.

HOSPITAL AFFILIATIONS St. Luke Hospital; Huntington Memorial Hospital, Pasadena, California; Traumatologist, Arcadia Methodist Hospital, Arcadia, California.

OUTSTANDING ACHIEVEMENTS Borden Freshman Prize; Alpha Lambda Delta; Phi Beta Kappa; Phi Kappa Phi; Bovard Award; ALD Award; American Institute of Chemists Medal Award; Summa Cum Laude, University of California; Alpha Omega Alpha.

"When you enter private practice, the only cases seen are usually those limited to your specialty. Serving as a physician in the Army Reserve offers me a departure from my daily routine. I can be involved in virtually anything I choose. If a certain case interests me, I can ask to be part of the surgical team. If I wish to spend time teaching students, I have that option, too.

"As a Reserve physician, I've had the opportunity to interact with different people, from various backgrounds, with assorted medical and social viewpoints. As a result, I've grown as a physician and as a person.

"I spent six months looking into the Army Reserve program before I joined, wanting to make sure that my skill and time would be put to good use. I've been a Reservist three years now, and I still find it extremely rewarding. I have the satisfaction of knowing that I'm serving my country."

Find out more about the medical opportunities in the Army Reserve. Call toll free 1-800-USA-ARMY.

ARMY RESERVE MEDICINE. BE ALL YOU CAN BE.

Because safety cannot be taken for granted in H_2-antagonist therapy

AXID®
nizatidine

Minimal potential for drug interactions

Unlike cimetidine and ranitidine,[1] Axid does not inhibit the cytochrome P-450 metabolizing enzyme system.[2]

Swift and effective H_2-antagonist therapy

- *Most patients experience pain relief with the first dose[3]*
- *Heals duodenal ulcer rapidly and effectively[4,5]*
- *Dosage for adults with active duodenal ulcer is 300 mg once nightly (150 mg b.i.d. is also available)*

References
1. USP DI Update, September/October 1988, p 120.
2. Br J Clin Pharmacol 1985;20:710-713.
3. Data on file, Lilly Research Laboratories.
4. Scand J Gastroenterol 1987;22(suppl 136):61-70.
5. Am J Gastroenterol 1989;84:769-774.

AXID®
nizatidine capsules

Brief Summary. Consult the package literature for complete information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to eight weeks of treatment. Most patients heal within four weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than one year are not known.

Contraindication: Known hypersensitivity to the drug. Use with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bilida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H_2-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

PV 2098 AMP [091289]

Additional information available to the profession on request.

Lilly
Eli Lilly and Company
Indianapolis, Indiana
46285

NZ-2924-B-049310 ©1990, ELI LILLY AND COMPANY

MEETINGS

1990 Annual Meeting
The Medical Society of Virginia
October 31-November 4

July 12-14
6th Annual Berkshire Medical Conference: Advances in Cardiology (University of Massachusetts), *Hancock, Massachusetts*. Berkshire AHEC, 413-447-2417.

July 13-15
Workshops in Traumatic Brain Injury Rehabilitation (Medical College of Virginia/VCU). *Virginia Beach*. CME Office, 804-786-0494.

July 16-20
Control of Biohazards in the Research Laboratory (Johns Hopkins), *Baltimore*. Byron S. Tepper, PhD, 301-955-5918, or Dr. Jacqueline Corn, 301-955-2609.

July 18-22
13th Annual Flap Dissection Workshop (Eastern Virginia Medical School), *Virginia Beach*. CME Office, 804-446-6140.

July 19-21
6th Annual Berkshire Medical Conference: Special Challenges in General Medicine (University of Massachusetts). *Hancock, Massachusetts*. Berkshire AHEC, 413-447-2417.

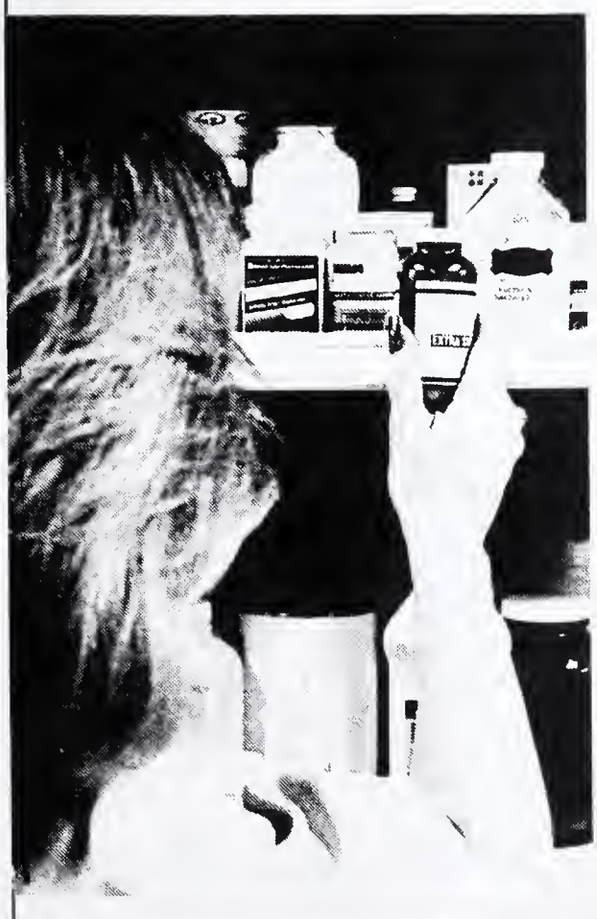
July 20-22
Practical Internal Medicine (Medical College of Virginia/VCU), *Virginia Beach*. CME Office, 804-786-0494.

July 26-29
40th Annual Scientific Assembly of the Virginia Academy of Family Physicians, Cavalier Hotel, *Virginia Beach*. 21½ credit hrs. VAFP headquarters, 804-358-1721.

July 27-29
12th Annual Pediatric Primary Care Conference: Pediatrics at the Beach (Medical College of Virginia/VCU), *Virginia Beach*. CME office, 804-786-0494.

August 10-12
Diabetes and Vascular Disease (Eastern Virginia Medical School), *Virginia Beach*. CME Office, 804-446-6140.

Continued next page



HEADACHE
THERE IS AN ALTERNATIVE

Headache is the most common disorder of modern man. It has been estimated that one out of three Americans suffers from severe headaches at one time or another.

The RICHMOND HEADACHE CENTER is a unique facility which specializes in the diagnosis and management of chronic and recurrent headaches.

The RICHMOND HEADACHE CENTER was founded by a group of practicing neurologists and clinical psychologists who recognized the need for a cooperative effort in treating chronic and recurrent headaches.

For more information, write or call .....

YES, please send me more information about RICHMOND HEADACHE CENTER.

NAME

ADDRESS

STATE

ZIP CODE PHONE

MAIL TO: RICHMOND HEADACHE CENTER
909 Hioaks Road, Suite I
Richmond, Virginia 23225

RICHMOND HEADACHE CENTER
909 Hioaks Road, Suite I
Richmond, Virginia 23225
Telephone (804) 320-3750

MORE MEETINGS

August 24-27
12th Edition, Practical Dermatology for the Primary Care Physician (Eastern Virginia Medical School), *Orlando, Florida*. CME Office, 804-446-6140.

September 8
Regular meeting of the Medical Society of Virginia's Council, *Richmond*. James L. Moore, Jr., 804-353-2721.

September 7-9
Annual Meeting/Scientific Session of the Virginia Vascular Society, The Homestead, *Hot Springs*. Dr. Jesse Davidson, program chairman, 703-345-1561.

September 10-14
Basic Course in Nosocomial Infection Control (University of Virginia). *Charlottesville*. Debbie Crickenberger, 804-924-2777.

September 28
13th Annual Perinatal Conference (Medical College of Virginia/VCU). *Richmond*. CME Office, 804-786-0494.

October 3-5
Recent Advances in Clinical Medicine (University of Virginia), Omni Hotel, *Charlottesville*. Lauvonda Young, 804-924-2090.

October 3-6
16th Annual Topics in Gastroenterology and Liver Disease (Johns Hopkins), *Baltimore*. 23.5 credit hrs. Physician fee: $425. CME Office, 301-955-2959.

October 4-6
Virginia Occupational Health Conference (Medical College of Virginia/VCU, *Richmond*. CME Office, 804-786-0494.

October 8-11
13th Annual Postgraduate Course in Radiology (University of Virginia), Boar's Head Inn. *Charlottesville*. 20 credit hrs. Fee: $400. Dr. Theodore E. Keats, 804-924-2781.

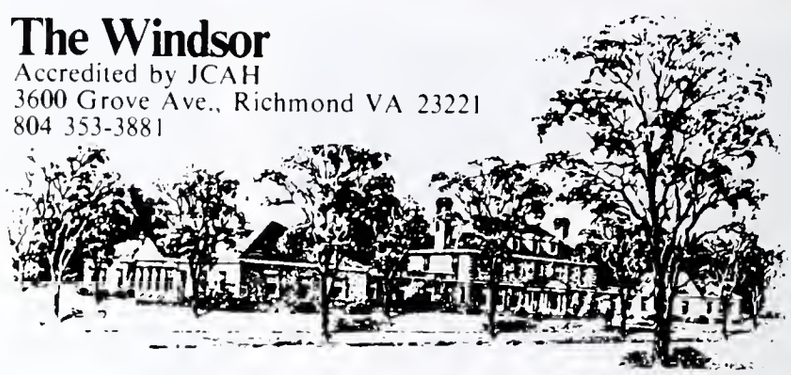
October 8-12
Basic Course in Nosocomial Infection Control (University of Virginia), *Charlottesville*. Debbie Crickenberger, 804-924-2777.

October 22-27
32nd Annual Emil Novak Memorial Course: Gynecology, Gynecological Pathology, Endocrinology, and High-Risk Obstetrics (Johns Hopkins), *Baltimore*. 44.5 credit hrs. Physician fee: $650. CME Office, 301-955-2959.

November 3
Symposium on Current Controversies in Colon and Rectal Cancer (University of North Carolina at Chapel Hill), *Research Triangle Park, North Carolina*. CME Office, 919-962-2118.

LONG-TERM CARE: IN SIXTH DECADE OF EXCELLENCE

The Windsor
Accredited by JCAH
3600 Grove Ave., Richmond VA 23221
804 353-3881



Mrs. Plyler's
Residential Care
1615 Grove Ave., Richmond VA 23220
804 353-3981

University Park
Accredited by JCAH
2420 Pemberton Rd., Richmond VA 23233
804 747-9200

BIOSYSTEMS HAS A WHOLE FAMILY OF UNIQUE INFECTIOUS WASTE DISPOSAL SOLUTIONS FOR DOCTORS

The number one disposal company on the east coast is expanding its family of infectious waste services to include doctor's offices and clinics.

BioSystems' unique disposal service eliminates your infectious waste problems with regularly scheduled pick up and delivery of our own containers by trained and qualified technicians. We've designed a full line of rigid and non-rigid containers to handle all of your infectious and medical waste. Just drop it in the box and we'll do the rest. Pick it up, document it, transport it, destroy it and leave you fresh containers at the point of use.

Choose from one of our safe, convenient and fully compliant programs that take the worry out of waste disposal. All for a fixed monthly rate designed to fit your budget. To help get you started, we'll visit your facility at no charge, and suggest a plan that suits your needs.

BioSystems is a licensed disposal service now serving over 85 major acute care facilities and over 2500 professional offices and clinics in the eastern U.S. region. All containers are transported in our own locked vehicles. Contents are destroyed utilizing only sound environmental techniques at our own facilities, eliminating the possibilities of mishandling by subcontractors.

To find out more fill out this form and drop it in the mail, or call us at (215) 672-8888.

Please send me more information on how to eliminate infectious waste in my facility.

_____ ( ) _____
Name Phone

_____
Facility or Institution

_____
Address

_____
City State Zip

Mail to: BioSystems Partners,
380 Constance Drive
Warminster, PA 18979

FAMILY PRACTICE

TRUST THE PEOPLE THE HOSPITALS TRUST

bio systems

New York: (516) 756-9433 • New England: (508) 921-2656 • New Jersey/Pennsylvania: (215) 672-8888 • Mid-Atlantic: (301) 840-1341

©1989 BioSystems Partners

Command Performances...

...Essential to Our Professions

How many times have you felt pressed into a command performance? Whether it's a treatment course or surgery, you feel all eyes are watching your every move. Expectations are high and, oftentimes, unrealistic. Then the unpredictable or the unwanted occurs. Those high expectations are not fulfilled and the next thing you know, you're being sued.

That's why our command performance is so important. When all eyes shift to the legal side, you want an insurance company backing you with excellent claims defense. At ICA, our claims defense is renown in the industry as tough and resourceful. We respond to a claim situation with in-house attorneys, not adjusters. And we use only the best defense counsel in your area, attorneys whose reputations and abilities present the one command performance you'll want to witness.

Call ICA today at 1-(800)-231-2615 and check out the reviews to our command performances.

ICA INSURANCE CORPORATION OF AMERICA
People Who Care Houston, Texas

The Auxiliary and the Teen-Ager

Notes and photographs from a big production starring healthy behavior

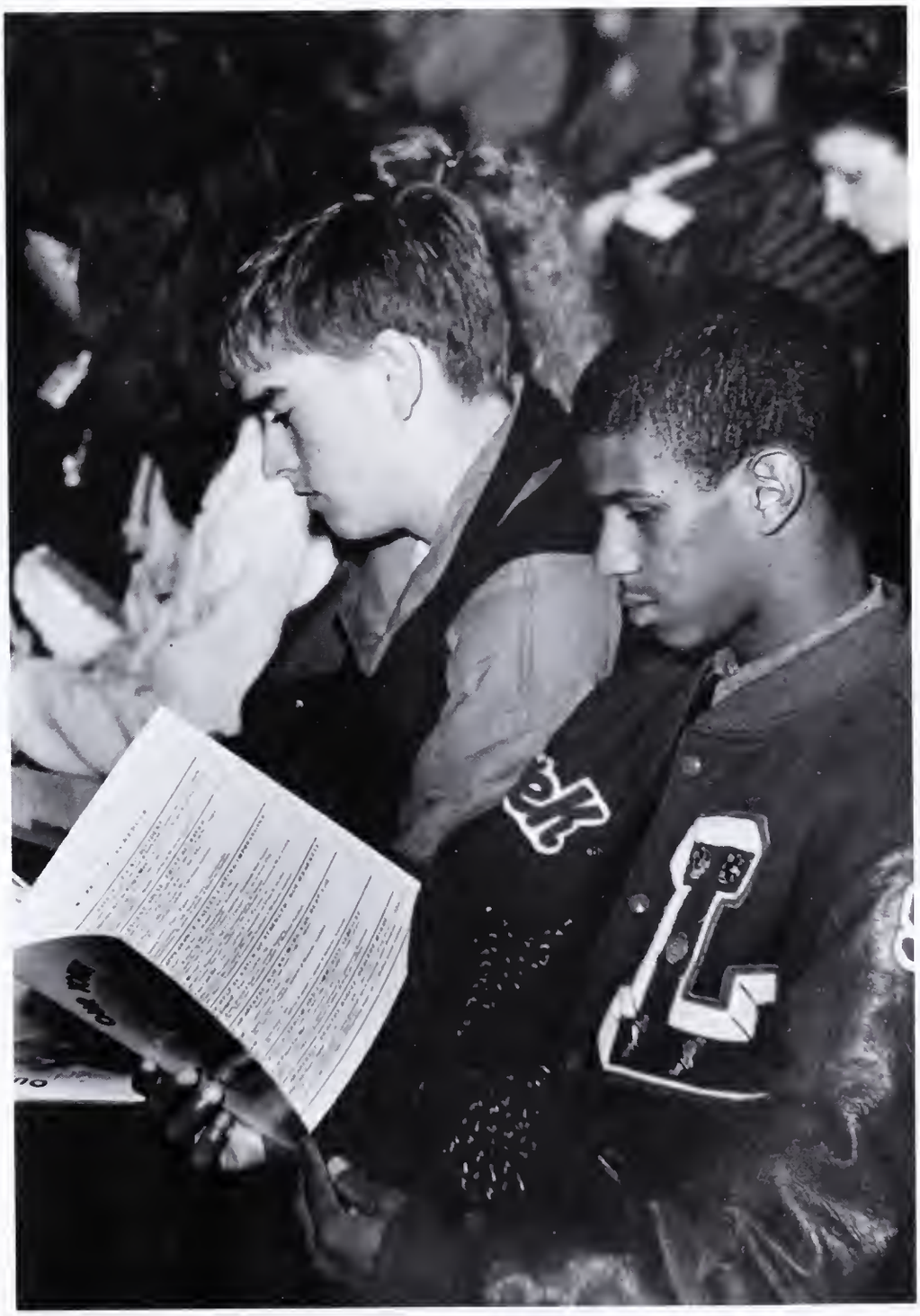
From all over Virginia the teen-agers and their teachers came, almost one thousand of them. A March snowstorm had slowed the yellow school buses, and the late-arriving youngsters made a beeline for the shelter of the Convention Centre in downtown Richmond. Their target was the Teen Health Forum, an all-day event organized by the Medical Society of Virginia Auxiliary to promote healthy behavior in Virginia's youth.

The Centre's big auditorium was

the youngsters' home room for this Tuesday learning experience. From the stage Mrs. Carroll T. Petty and Mrs. Phillip Thomason, MSVA president and vice president, and Dr. William H. Barney, Medical Society of Virginia president, welcomed the youngsters. They were followed by the keynote speaker, Mike Green, once an all-star high school athlete and now a recovering alcoholic who has been off the booze for twelve years. He looked young, he talked young, and he had showmanship; with volunteers from the audience, for example, he put on little playlets illustrating ways to combat the peer pressure of drug users. Next Miss Virginia, Tami Elliott, accompanied by high-decible music, wrapped up the audience by bounding and flipping all over the stage in a high-energy gymnastic exhibition.

At mid-morning the teen-agers adjourned en masse for the serious stuff, the breakout sessions. At the other end of the Centre and up one flight eleven classrooms were in readiness. Eleven presenters, most of them physicians, were ready, too, to lead discussions on such topics as sexuality, drug abuse, emotional disorders, self-image, fitness and exercise. Which to choose, that was the question. Postponing teen-age sexuality? Eating disorders? The perfect diet? Sexually transmitted diseases/ AIDS? Steroid abuse? Tobacco abuse? Date rape? Teen suicide? Teen pregnancy? Exercising safely? Driving safely? Finally everyone was settled in the session of choice—but for the afternoon sessions, everyone had to choose all over again.

At noon there were 1,000 box lunches for the taking, and students



and teachers picknicked together in the Centre's hallways. Then came another galvanizing interval in the auditorium, where students of the Virginia Karate Society performed dramatic feats of self-defense and the heavy beat of the House Patrol, a rapper and dancers band, vibrated compellingly through the hall. The winners of the essay contest ("Our Youth—Our Future") stepped up to the stage to receive from their peers a big hand and from Mrs. Petty some big checks ($500, $250, $125). Late in the day, as a going-away present, all teen-agers and teachers received T-shirts imprinted with the Teen Health Forum's logo.

It was a gigantic production, and the persons who made it go, from start to finish, were Vivian Petty and Eileen Thomason.

Two other prime movers and shakers were S. John Davis, PhD, superintendent of public instruction for Virginia's schools, and Jeane L. Bentley, of the State Department of Education.

Key roles were played by these physicians who worked up and conducted breakout sessions: Dr. Michael E. Bohan, Portsmouth; Dr. David R. Faber II, Norfolk; Dr. Warren P. Klam, Falls Church; Dr. Greg Leather, Arlington; and from Richmond, Dr. Lawrence E. Blanchard III, Dr. Kevin R. Cooper, Dr. Hazel S. Konerding, Dr. Dean X. Parmalee, Dr. Harold F. Young, and Dr. Joseph R. Zanga.

And these groups contributed that vital ingredient, money: Norfolk Academy of Medicine Auxiliary; Portsmouth Academy of Medicine Auxiliary; Portsmouth General Hospital Foundation Fund; Maryview Medical Center; Johnston-Willis Hospital; St. John's Hospital; Chippenham Hospital; St. Mary's Hospital; Allen, Allen, Allen & Allen; Virginia Insurance Reciprocal; and Southern Health.

—A.G.

Photographed at right, Dr. Greg Leather's breakout session on exercising safely.
Below left, Miss Virginia onstage.
Below center, Dr.Warren Klam in hallway with students and teacher after his session on drug abuse.
Far right below, Dr. Michael Bohan's session on steroids.

Photographs by Taylor Dabney

POINT OF VIEW

Legalizing Drugs: A Few Simple Questions

As time passes, more and more people are suggesting that recreational street drugs be legalized. Aside from a few libertarians, most people offer the rationale that decriminalizing usage will remove the profit motive and therefore the presence of drug pushers. They seem to be saying that if you can't lick them, join them, and at the same time unclog the legal and penal systems; however, details about what will take the place of the present system are vague, and perhaps a few simple questions are in order.

The first question to be asked is, who will be selling the drugs, the private market place or the government? The former is less likely, but if the private sector is given the task, will it be on a monopoly basis or on the basis of competition within the free enterprise system? If a monopoly, who will get it and how will it be regulated? If regulated, by whom? How will prices be set? Will it be regulated like a utility or will the sellers be free to charge what the market will bear? Which drugs will be sold and will the sellers be free to introduce new drugs on their own? If competition is the order of the day, will advertising be permitted, at least to the extent that tobacco and alcohol products are permitted to advertise? If not, and it is legal, why not? Will "specials" be allowed to be offered to increase the user population? Will new "designer" drugs be developed and marketed? Will exports be permitted, to improve our balance of payments?

If, as is more likely, the government takes on the task, will it be in the hands of the local, state or federal government? If either of the former, won't chaos result from different regulations, different drugs permitted to be sold, and at different prices? Since that is likely to happen, it would fall on the federal government to sell the drugs out of "state stores" as some states now sell liquor. Now a host of new questions arise. Would the government advertise? Would it sell all drugs or just some, leaving the market for the others in the hands of drug dealers? Would it take the lead in introducing new drugs, such as the "ice" coming in from Japan, or would it leave that to the dealers? Would it set prices high to discourage use and therefore open the market to "moonshiners," who would be able to sell cheaper because of less fixed costs (one can imagine the size of the bureaucracy it would take to set up such a program), or would it set the price low and thereby encourage broader usage? Would it be restrictive in its sales practices, trying to discourage abuse (and thereby making it easier to go to your neighborhood pusher), or would it be lenient, thereby encouraging broader usage? Obviously, it would not sell to minors, but does anyone familiar with teen-agers doubt their ability to obtain the drugs one way or the other? If not sold to minors, would this not leave this entire market open to drug dealers? In the name of "fairness" would the government distribute the drugs free of charge to indigents? Will this become a basic right discovered somewhere in the Constitution? Not if, but when side effects occur, will it be the responsibility of the government, since it is doing the selling, to provide appropriate care? Will this open the door to a whole new class of lawsuits? If an addicted or deformed or impaired baby is born, will it be the responsibility of the government to care for it? Forever?

If it is decided to distribute the drugs through clinics run by physicians, new questions arise. Again, will they be limited to some drugs or to all? Will it be limited to addicts or to anyone who expresses an interest in them? If the former, will not the recreational drug users, who are in the majority, continue to get their supplies from dealers? With addicts, who decides how much is enough to satisfy their needs? If the clinic staff decides, will not many addicts take the pure drug, adulterate it, and become dealers themselves, so that they have money to meet their needs, as they and not the clinic determine it? Will addicts be forced to undergo treatment, and if so, is it a violation of their rights as some people would undoubtedly see it? What will be considered an acceptable recidivism rate when requests come to the Congress or the state legislatures for refunding? What would be the total costs of such a program?

Currently those who smoke can do so in smoking lounges or sections of restaurants designated for smokers, while those who wish to imbibe alcohol in convivial company and surroundings can do so in a wide variety of bars, taverns, restaurants, clubs, etc. Is there any reason, with recreational drugs legalized, why there should not be similar places for those who wish to do the same with drugs? Could we deny the opening of shooting galleries for heroin, crack and coke bars and the like? Perhaps we could even have a TV sitcom based on the friendly camaraderie which

would exist in one of these establishments.

If recreational drugs are legalized, why should we keep intact the elaborate system to supervise the dispensing of controlled substances—narcotics, tranquilizers and the like? Why should we not sell morphine and codeine and their derivatives over the counter, next to the aspirin, acetaminophen and ibuprofen? Why should we not sell major tranquilizers and sedatives the same way? Why not all prescription drugs?

A further concern is the educational system we have painstakingly put in place over the past two decades against abuse of alcohol, tobacco products and recreational drugs. How seriously will anyone take these campaigns when the government passively (in effect actively) endorses the use of recreational drugs? Virtually everyone across the political spectrum agrees that a fundamental role of government is to maintain public safety. What amount of testing will be necessary to protect us from harm? We immediately think of airline pilots, air traffic controllers, railroad engineers and tanker captains, but would not everyone who makes decisions which affect our health and welfare be subject to testing? Would this not include all vehicle drivers? What size police and support system would be necessary to screen the roads for drug use in addition to alcohol use? We are aware of the increasing competitiveness of the world economy. Is legalization of drugs likely to improve or decrease our productivity and competitiveness?

There are obviously many more questions to be asked and the ones asked above will undoubtedly raise many more related ones; however, the greatest questions relate to our ability, and will, to deal with difficult and dangerous problems. Is our solution to such a difficult and intractable problem to give in to it, or to devise effective ways of fighting it? If this problem is difficult, aren't many of our other social problems? Should we give in to them as we give in to this? The answer depends on where we are going as a society.

DAVID A. ZOHN, MD

Dr. Zohn is in the private practice of physical medicine and rehabilitation at 1515 Chain Bridge Road, Suite 102, McLean VA 22101.

Cocaine: Recognizing, Treating the Abuser

Peter Coleman, MD
Richmond, Virginia

COCAINE is taking a severe toll of the people and industry of this nation. It has become increasingly linked with new AIDS cases, with sky-rocketing crime and murder rates in many of our cities, and there are increasing numbers of cocaine-addicted pregnant mothers. Cocaine-related deaths in the United States increased by over 300% between 1982 and 1985.[1] While there is some evidence that attitudes about cocaine are beginning to improve and that use of cocaine is beginning to decline in upper-middle class sectors of our society, there is no end in sight for the devastation that this drug is producing.

History and Epidemiology

Cocaine is found in the leaves of the coca plant (no relation to the cocoa plant, from which chocolate is made). The coca plant is indigenous to many countries in South America. The effects of the plant have been known since around 500 AD but it was not until the late 1800s that the active drug was isolated and its effects described. There followed a small epidemic, which seemed to terminate a few years later, partly due to passage of the Harrison Drug Act of 1914. The serious consequences of cocaine addiction were well described at this time. Sigmund Freud was one of the many well-known people who used the drug; he advocated its use to treat alcohol and morphine addiction. Interestingly, it was not too much later that morphine was being tried as a cure for cocaine addiction![2] Following this small epidemic, cocaine use remained uncommon and fairly much confined to use by addicts of other drugs, especially heroin. In the late 1960s cocaine use began to increase, initially glamorized by the media and the elite of society. Until 1980 it was perceived as a non-addictive and harmless drug with as few problems as marijuana. Even the medical profession regarded cocaine as relatively harmless. In 1980 the official manual of the American Psychiatric Association, the DSM III, did not recognize cocaine as having a withdrawal syndrome or producing dependence.[3] Use rapidly spread throughout society and

Dr. Coleman conducts a private practice in addictive diseases. Address correspondence to him at 2115 Grove Avenue, Richmond VA 23220.

Submitted 12-28-89.

has now spread across all socioeconomic boundaries.

Pharmacology

Cocaine exists in the plant as a base, and its extraction involves the addition of a strong acid to form cocaine hydrochloride. In this form it is a white crystalline powder which is readily soluble in water but has a very high vaporization point. Cocaine is used in predominantly three ways. 1) Most commonly cocaine hydrochloride is insufflated up the nose so that it can be absorbed through the nasal mucosa. Absorption takes from 1-3 minutes and is probably less than 50% complete because of the intense vasoconstriction that the drug causes. 2) Much less commonly, cocaine hydrochloride can be dissolved in water and injected intravenously. This method is often used for addicts who already abuse heroin, is 100% efficient and the effects begin in only 30-120 seconds. 3) The most rapidly increasing method of use is for cocaine users to smoke the drug as the "free-base." Freebase, or "crack," is produced when the chloride ion is removed from cocaine hydrochloride. This can be done fairly readily at home, but drug dealers have recently learned that they can mass produce the freebase and sell it as the more potent form under the name of crack. Crack is so-called because of the sound it makes when vaporized in a pipe. Crack or freebase has a much lower vaporization point than cocaine hydrochloride and is easily smoked in a pipe. It is rapidly absorbed through the lungs, and because the pulmonary circulation then carries the drug directly to the left ventricle and on to the brain, its effects begin in only 5-10 seconds. It thus produces a very intense high, which leads to an equally intense crash. There follows a very strong desire to repeat the experience and attempt to regain the pleasurable feelings.

Clinical Effects

Cocaine causes an increase in sympathetic tone with vasoconstriction, hypertension and tachycardia. It has been found to cause cerebrovascular accidents, TIAs, myocardial infarction, angina and ruptured ascending aorta.[7] In addition, it is known to cause seizures and ventricular arrhythmias. If used intravenously it is associated with thrombosis, sepsis, bacterial endocarditis and AIDS. Intranasal use frequently leads to chronic rhinorrhea, inflammation and sometimes a perforated septum. Use during pregnancy, even the first trimester, is associated with spontaneous abortion, placental abruption and stillbirth. The infants may be very irritable, have problems learning, cerebral hemorrhage, neonatal seizures or other birth defects, including genitourinary anomalies and ileal atresias.[8]

In general, people using cocaine report that they feel euphoric, powerful, energetic, and very much in control. They become talkative, excited, self-confident and even grandiose and out of touch with reality. There seems to be an increase in sexual libido at low doses although at higher doses a decrease in sexual performance develops. There is usually some anxiety caused by cocaine use and this becomes much worse at higher doses. Physically, there is an increase in pulse rate and blood pressure, some muscle contractions occur, and there may be urinary and bowel retention. At toxic levels a marked anxiety develops, as well as a serious loss of judgment and paranoid delusions.

The acute, intense euphoria generally lasts only a few minutes and is replaced by a less intense euphoria with increasing anxiety and signs and symptoms of sympathetic discharge. This period of less intense euphoria lasts about 30-90 minutes and is gradually replaced with increasing feelings of anxiety, dysphoria, distress, depression and drug craving—the cocaine crash. Users report that during this cocaine crash they feel intensely uncomfortable and they will often go to extraordinary lengths to avoid these negative feelings. Many users take large amounts of alcohol or other sedatives to avoid this dysphoria.

Chronically, cocaine use causes a wide variety of problems. Most commonly users begin to feel out of control and depressed. There is a disruption of sleep patterns and appetite. There is a generalized loss of interest in life, or anhedonia. Initially these feelings of depression and anhedonia can be relieved by more cocaine, but most chronic users report that they can never quite recapture the good feelings that cocaine originally produced. Some chronic abusers use the drug on a daily basis, but a more common pattern is of binge use about 2-3 times per week. Abusers will start on a binge, often associated with payday, and then not stop until the supply is exhausted, often 2 or 3 days later. This binge pattern gives the abuser some illusion of control since many abusers believe that if they can go for 3-5 days without using, then they can control their use any time they choose to.

Even though the medical problems associated with cocaine abuse are dramatic, they are reasonably uncommon, and if physicians wait for these problems to arise they will be missing a lot of cocaine abusers who come into the office. It is important, then, for all physicians to consider cocaine abuse with all patients. Usually a straightforward question, as part of a general health appraisal, asking whether cocaine has ever been used will elicit an honest response. If the response is in the affirmative, then a followup question of whether cocaine has ever been a problem will be a useful introduction to talking about the subject.

Neurochemistry

Cocaine exerts its effects on a number of neurotransmitter systems, although the exact details are not completely clear. Animal experiments and human objective and subjective experience seems to point to the dopamine system as being the system most responsi-

ble for cocaine's effects.[4] Cocaine rapidly blocks the reuptake of dopamine into the presynaptic nerve cleft and thus allows dopamine's action to be intensified and prolonged. There may in addition be increased dopamine synthesis, and there is reason to suspect that there follows an "up-regulation" of dopamine receptors, which refers to the ability of the nervous system to try to achieve a homeostatic state in the face of too much neurotransmitter. The actual number of dopamine receptors seems to increase, probably in an attempt to use up the excess neurotransmitter. Unfortunately, what ultimately occurs is that these increased receptors then seem to "demand" higher levels of dopamine to occupy them, and this probably accounts for some of the severe drug craving that addicts experience once the cocaine is finished. While cocaine makes more dopamine acutely available in the central nervous system, it causes chronic dopamine depletion, as all of the dopamine is kept in the synaptic cleft and therefore rapidly broken down.

Cocaine's stimulation of the dopamine system seems to occur in the limbic system, the basal ganglia and substantia nigra. The limbic system, and predominantly the nucleus accumbens, are intimately connected with the brain's pleasure and reward centers. These areas are strongly associated with the brain's primitive drives for food, water and sex and are generally under less conscious control than other "higher" areas of the brain.

Experiments with animals and in humans reveal that cocaine is intensely addicting physically.[5,6] Experiments with animals have revealed that animals will prefer cocaine over most other known drugs and over food and water. If left alone with all the cocaine they can use, 90% of animals will be dead in 30 days (as opposed to 36% with heroin). Animals will continue to seek cocaine even if they receive an electric shock paired with the cocaine. Some researchers train animals to self-inject drugs until the animals become addicted to the drug. Once an animal has become addicted to a drug an experiment can attempt to determine how addictive that drug is by monitoring how often the animal will continue to press the lever to try to get more drug, even after the drug supply is turned off. For Valium,® the average number of lever presses after the drug supply is turned off is 50 presses, for heroin it is 500 presses, for cocaine the animals will continue to press the lever an average of 12,000 times even after the cocaine supply is turned off. Our experience with human addicts also indicates that the drug is intensely addictive and the cravings powerful.

Treatment

Treatment is best performed in a specialized setting staffed by professionals experienced with drug and alcoholism patients. During the cocaine crash patients usually require little more than supportive therapy. Following the cocaine crash (1-5 days), treatment is similar to that generally accepted for other drugs of abuse, with some distinct differences. It is generally accepted that it is important for patients to abstain from all mood-altering drugs, including alcohol.[9]

Group therapy is generally felt to be the most effective technique to help the patient realize and accept how serious the cocaine problem has become. The goal of early treatment is to have the patient be able to diagnose himself as having a drug problem, as a means to allowing him to accept fully how serious the problem has become. Helping patients to overcome this denial is very difficult and in practice this process frequently takes a number of weeks. The denial for patients with cocaine abuse problems seems to be a little different from that associated with patients who abuse alcohol. Cocaine addicts seem to accept readily that they are unable to control their use once they start using cocaine; their denial seems to involve a difficulty in accepting how difficult it will be to avoid returning to the drug even after they have gone through withdrawal and become drug-free.

Once the patient has accepted the nature and severity of the problem, he or she needs to learn and practice relapse prevention. This is a complex issue and individual needs vary from patient to patient. First, triggers that elicit cocaine cravings should be identified and then contingency planning can be arranged. This obviously involves avoiding people and places where there is current drug use, and it is also best to avoid people and places that were associated with previous use. It may involve changing phone numbers or even moving to a new address, to avoid drug dealers who may attempt to entice patients back to cocaine use. It may involve having a friend pick up a pay check and bank the money. It always involves destroying or removing all drug-related paraphernalia and any secret supplies.

Regular attendance at 12-step recovery support groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or Cocaine Anonymous (CA) is probably the most important aspect of relapse prevention. Other aspects include regular exercise, which helps to normalize brain neurochemistry and combat some of the anhedonia, and stress management techniques to help anticipate stress, recognize it and learn how to feel calm without using drugs.

Involving the family in the recovery process is an important part of treating the abuser. Family members have often been severely affected by the drug use and the behaviors associated with it. Often the families have a lot to learn about drug problems, and experience tells us that if family members are involved with their own recovery process, patients are more likely to recover.

The majority of treatment for cocaine is currently performed in an inpatient setting rather than an outpatient setting. While the hospital setting provides the most security from early relapse, it is not clear if it

"Nearly 3,600 physicians in Virginia have their history with us. So can you."

Your peers in the medical community depend on the expertise of The St. Paul and our knowledge of their business.

Why? Because they receive stable, high limits coverage backed by a company with more than $10 billion in assets and nearly 40 years of experience in Virginia. Expert service is provided by local claim, underwriting and legal personnel who understand the Virginia medical liablity environment.

You can depend on us. Now, you too can start your history with us.

Call your independent agent representing The St. Paul.

Or call Jeff Hanger, Medical Services Manager, of The St. Paul's D.C. Area Service Center at (703) 818-7310 or 1-800-572-3324.

The St Paul

helps with long-term recovery rates. Considerable research is currently underway to attempt to resolve these issues and in the meanwhile it is reasonable to recommend outpatient treatment as an initial treatment if the patient can remain drug-free for a number of days.

Pharmacotherapy

A search has been under way for pharmacotherapeutic aids to help the cocaine addict begin and stay abstinent. A number of drugs which have effects on the dopamine system have been studied.

Bromocryptine (Parlodel®), a drug used mostly in the treatment of patients with Parkinson's disease, is a dopamine agonist. An initial open trial of bromocryptine by Gold and Dackis[11] indicated some decreased cocaine craving when bromocryptine was used in a group of cocaine addicts. More recently, however, a double-blind study indicated that almost 60% of the patients taking bromocryptine had to drop out of the study because of side effects and only about 15% continued the study for the required 10 days.[12]

Amantadine (Symmetrel®) has a mechanism of action to increase dopamine's effects, and it, too, is used in Parkinson's disease. It does not appear to have an abuse potential and seems to have a decreased side-effect profile when compared to bromocryptine. Tennant studied 50 patients receiving amantadine in an open trial and reported substantial, immediate reductions in cocaine craving.[12] Two other groups of researchers, however, have reported only a slight decrease in cocaine craving after one to two weeks and these trials had very high dropout rates.[12]

Early animal experiments have indicated that tricyclic antidepressants (TCAs) may be useful in reversing some of the neurotransmitter effects of stimulants. Initially Tennant and Rawson evaluated the effects of desipramine in cocaine addicts, and their initial results looked promising. Since then at least five other open studies have reported generally positive results, with Gawin and Kleber reporting results as high as 80-92% abstinence.[13] Unfortunately, in all of these studies there has been a delay in onset of effect of 1-3 weeks. A number of double-blind trials have recently been started and results so far have been mixed. In a small study Gawin and others reported initial abstinence rates of 57% with desipramine versus only 17% with placebo,[13] but other results have not tended to support these findings. It is not clear what effect desipramine may have on long-term abstinence rates. Side effects from TCAs have generally been low, but a recent study of cocaine-induced panic attacks indicated that treatment with TCAs often worsened the problem.[14] In addition, some recent case reports have suggested that TCAs used past 4-5 months after the last cocaine use may produce intolerable anticholinergic effects, dysphoria or even increased cocaine craving.[15]

Clearly, an ideal pharmacotherapeutic agent has not

emerged. Ongoing research is continuing with the above agents and others including carbamezepine, clonidine and newer antidepressants.

Conclusion

Cocaine is a very powerful drug and recovery is a difficult and slow process. Current treatment methods are frequently successful and there is reason to hope that in the near future research will enhance these success rates. It is important for physicians to consider cocaine abuse as a problem for any patient they are treating, and to offer them assistance or referral if they need it.

References

1. Macdonald DI. National survey of drug abuse. JAMA 1986; 256:23 3201
2. Smith DE. Cocaine-Alcohol abuse: Epidemiologic, diagnostic and treatment considerations. J Psychoactive Drugs 1986; 18:117-129
3. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Diseases III (DSM-III). Washington DC, American Psychiatric Association Press, 1980
4. Dackis CA, Gold MS. New concepts in cocaine addiction: the dopamine depletion hypothesis. Neurosci Biobehav Rev 1985; 9:469-477
5. Wise R. Neural mechanisms of the reinforcing action of cocaine. Natl Inst Drug Abuse Res Monogr Ser 1984, 15-33
6. Bozarth MA, Wise RA. Toxicity associated with long-term intravenous heroin and cocaine self-administration in the rat. JAMA 1985; 254:81-83
7. Creglar LL, Mark H. Medical complications of cocaine abuse. N Eng J Med 1986; 315:1494-1499
8. Chasnoff IJ, Griffith DR, MacGregor S et al. Temporal patterns of cocaine use in pregnancy—perinatal outcome. JAMA 1989; 261:1741-1744
9. Smith DE. Diagnostic, treatment, and aftercare approaches to cocaine abuse. J Subst Abuse Treat 1984; 1:5-9
10. Rawson RA, Obert JL et al. Cocaine treatment outcome: cocaine use following inpatient, outpatient, and no treatment. Natl Inst Drug Abuse Res Monogr Ser 1986; 271-277
11. Dackis Ca, Gold MS. Pharmacologic approaches to cocaine addiction. J Subst Abuse Treat 1985; 2:139-145
12. Gawin FH. Chronic neuropharmacology of cocaine: progress in pharmacotherapy. J Clin Psychiatry 1988; 49(2):11-16
13. Gawin FH, Kleber HD, Byck R et al. Desipramine facilitation of initial cocaine abstinence. Arch Gen Psych 1989; 46:117-121
14. Louie AK, Lannon RA, Ketter TA. Treatment of cocaine induced panic disorder. Am J Psych 1989; 146:40-43
15. Weiss RD. Relapse to cocaine abuse after initiating desipramine treatment. JAMA 1988; 260:2545-46

20-Year Survival of von Hippel-Landau Hemangiomatosis: Case Report

Leo Goldhammer, MD
Arlington, Virginia

Von Hippel-Landau disease is a rare familial disease, transmitted as an autosomal dominant trait, characterized by retinal angiomatosis (von Hippel tumor), cerebellar hemangioma, and multiple visceral masses, including cavernous angioma of the liver, cyst or adenoma of the pancreas, kidney and epididymis, renal cell carcinoma and pheochromocytoma. We present a patient with von Hippel-Lindau disease who, over a period of 20 years, underwent successful resection of 11 neuraxial hemangioblastomas affecting the frontal lobe, cerebellum, medulla oblongata, spinal cord and retina.

Case Report

About 20 years ago a 43-year-old patient awoke with foggy vision and dark spots in the left eye. Ophthalmologic examination revealed multiple retinal angiomas bilaterally. She underwent retinal surgery but subsequently developed progressive loss of vision leading to complete blindness in the left eye. The following year, neurologic evaluation revealed loss of proprioception and light touch in the left upper extremity. Although the patient underwent posterior fossa exploration, the tumor was considered inoperable and was not resected.

Three years later, the patient complained of paresthesias, weakness and wasting of the extremities, and dysesthesias of the hands and arms. She developed a staggering gait and gradually progressing akinetic mutism.

A ventricular peritoneal shunt was performed five years later. The patient regained consciousness and ocular bobbing, previously noted, stopped the morning after surgery. In three weeks she was able to walk, but demonstrated broad-based staggering and sensory deficit for all modalities in the upper extremities. The optic disk had the appearance of a subsiding papilledema. The patient was alert and well-oriented.

Late in the same year, seven hemangioblastomas

Dr. Goldhammer is in the private practice of neurology at 611 South Carlin Springs Road, Suite 303, Arlington VA 22204.

Submitted 12-28-89.

were removed. These included one large and two small angiomas on the right cerebellar hemisphere, another angioma between the left tonsil and corpus restiformis, two small dorsolateral angiomas with origins at C1 and C2 and one intramedullary angioma (Figs. 1A and 1B, 2A and 2B. The arteriogram did not reveal all of the existing tumors.)

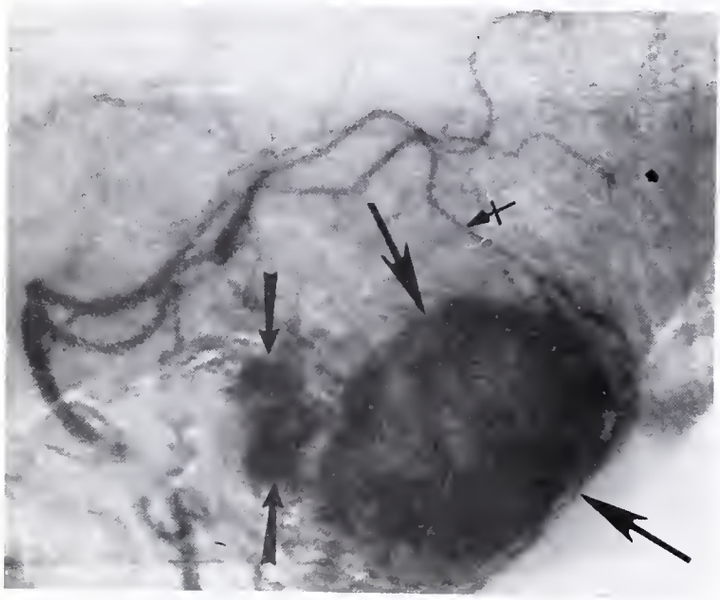
After surgery, there was a continuum of disordered extraocular movements in any direction (opsoclonus). These microsaccades were followed in the ensuing weeks by short bursts of horizontal oscillations (flutter), which were replaced by dysmetria.

Two years later, the patient's condition became slightly worse. One large and two small recurrent hemangioblastomas were successfully removed from the cerebellar hemispheres and anterior vermis. Five years later, a frontal lobe meningioma was resected (Fig. 3).

Family History

The family history confirmed the autosomal dominant inheritance pattern characteristic of von Hippel-

Fig. 1A (left). Film indicates vascular lesion at C2-C3. Feeder arteries (arrows) arise proximally and distally from right vertebral artery. Fig. 1B. Same view after surgical removal of lesion.



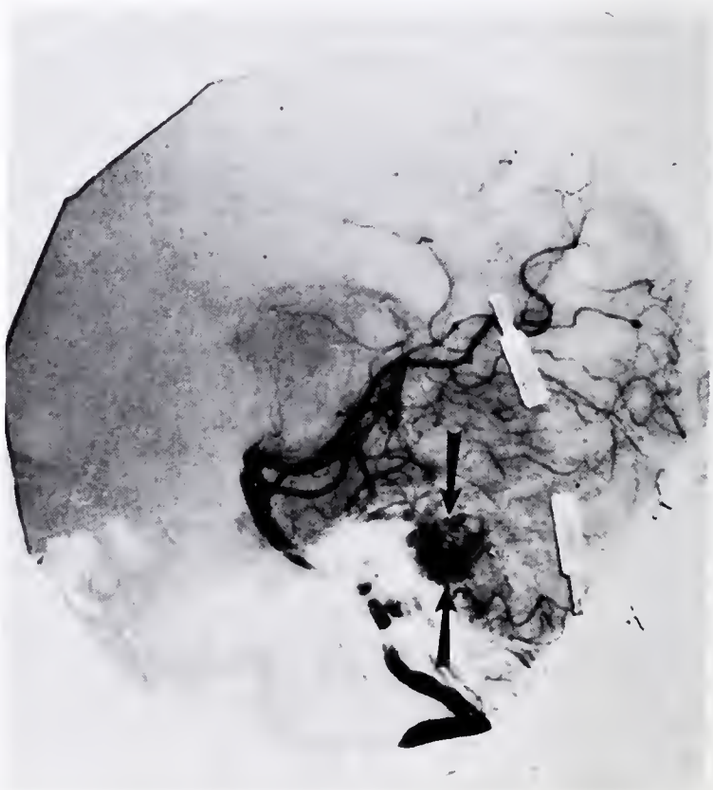


Fig. 2A (left). Preoperative lateral projection of vertebral artery angiogram reveals two distinct vascular mass lesions in posterior fossa (arrows). Larger lesion is supplied by dilated branch of superior cerebellar artery (crossed arrow). Fig. 2B. Postoperative lateral view. Larger hemangioblastoma removed. Second, smaller lesion still visualized (arrows).

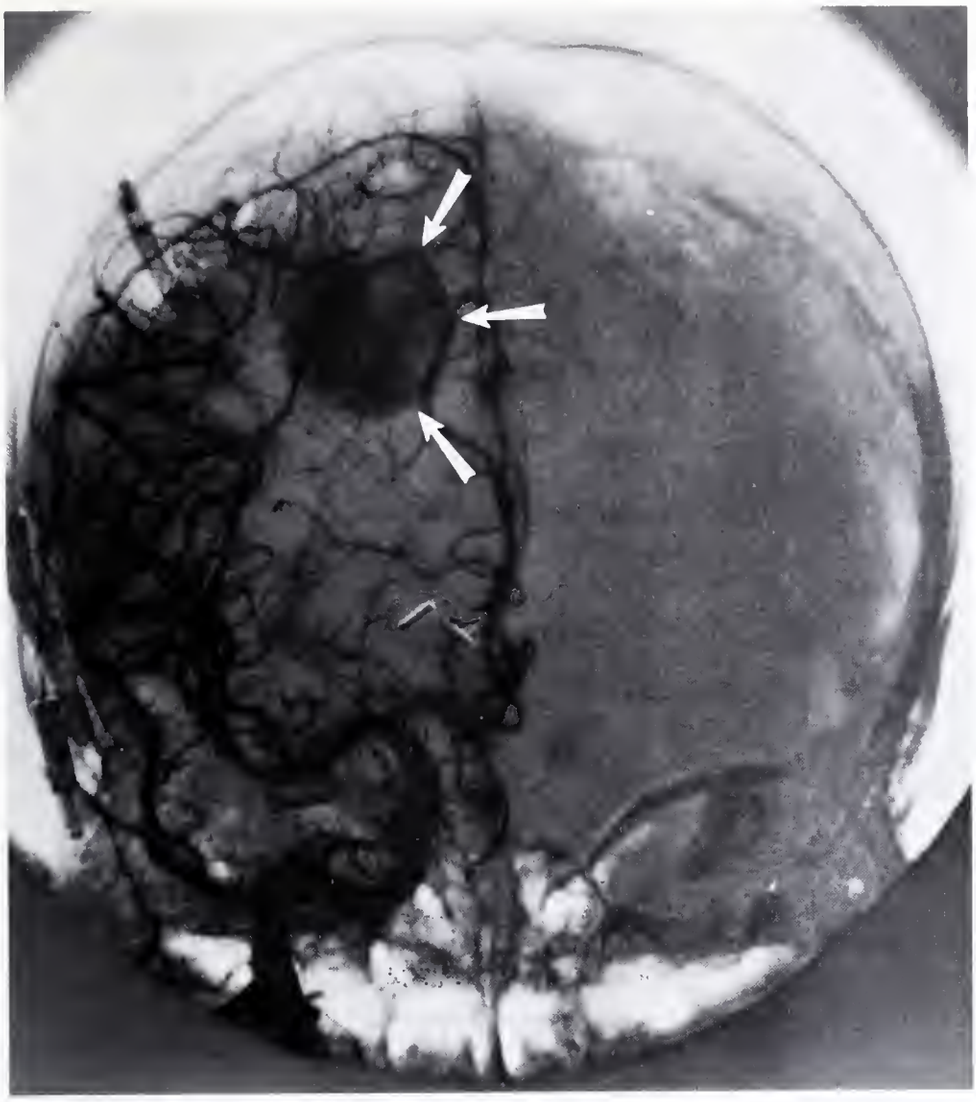
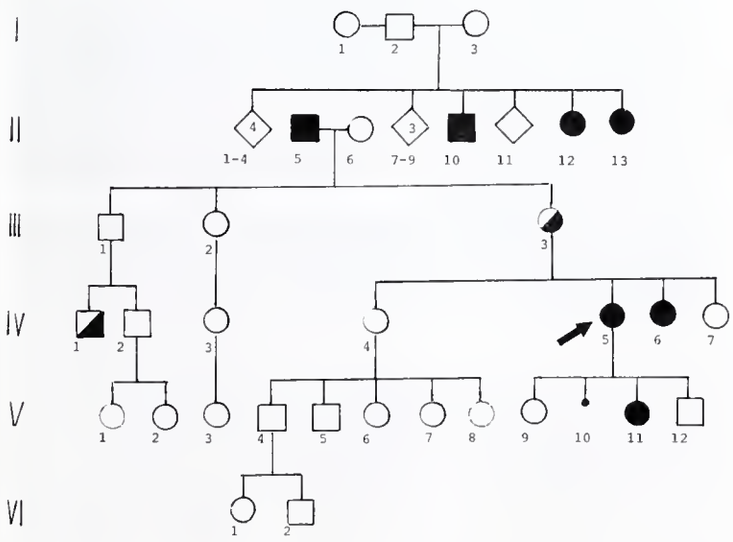


Fig. 3. AP view demonstrates large vascular mass in right frontal lobe.

Lindau disease. In the pedigree (Table 1), the propositus is indicated by the arrow at line IV, number 5. Her sister died at age 24 of pheochromocytoma, preceded by a history of malignant hypertension. Another sister died at 2 months of age of congenital cardiac malformation. The patient's mother died of brain tumor at age 29. The patient's uncle is said to be normal but produced a son who is reported to be blind in one eye, with an angioma as the suspected cause. An aunt at the age of 76 is epileptic but exhibits no other symptoms.

Table 1. Genetic Family Tree of the Propositus.



The maternal grandfather is reported to have died at age 46 of von Hippel-Landau disease. Three of the grandfather's siblings are reported to have gone blind at early ages, presumably due to retinal angioma.

The propositus had four pregnancies and three live-born children. One child, a girl, had a pheochromocytoma and a pancreatic cyst, which were successfully removed. The other two children (V-9 and V-12) are at this time symptom-free.

Comment

Hemangioblastoma is a non-metastasizing tumor which may occur anywhere in the body.[1-3] Treatment is entirely neurosurgical, and irradiation does not influence the course of the disease.[4,5] The best prognosis is associated with angiomatous cysts. Photocoagulation is somewhat effective in the early stages of the disease. A good prognosis is also associated with resection of the hypernephroma before it metastasizes. Onset of symptoms may occur at any time between 3 and 50 years of age and is heralded by either visual or, less often, neurologic disturbances. Few cases have been reported to start in the sixth decade. Patients in older age groups have a more protracted history, sometimes for years, whereas younger patients have a more acute onset of only a few weeks' duration. Sometimes the disease is heralded by mental

Table 2. Screening Program for Patients at Risk for von Hippel-Landau Syndrome.[14]

Family history and pedigree analysis
Physical exam, including blood pressure
Neurological exam
Ophthalmological exam with contact glass
Abdominal ultrasound imaging
Blood cell count
Urine sediment
Urinary catecholamine excretion

Additionally, for exploration of pathological or equivocal findings: cranial and/or abdominal CT scanning or MR imaging, metaiodobenzylguanidine (MIBG) scintigraphy of the adrenal glands.

Annual cranial CT scan for all individuals at risk, first-degree relatives of hemangioblastoma patients, has been recommended.[15]

changes mimicking a frontal lobe tumor. Trauma is implicated in cyst formation and is believed to accelerate the course of the disease. The sequential group of oculomotor disorders (opsoclonus, followed by flutter and finally dysmetria) after removal of the tumors, suggests that these conjugate disturbances of the eyes may be considered as a continuum in which saccadic movements become more and more precise during the recovery process. In spinal cord hemangioblastoma,[6,11] symptoms are related to location, extent and developmental stage of the tumor. The spinal mass may be asymptomatic before the third decade, after which its usual intramedullar location in the posterior tier is associated with progressive proprioceptive deficits. A subtle distinguishing feature between hemangioblastoma and other intramedullary tumors is the absence of sphincter involvement and sacral sparing in the former. The level of cerebrospinal fluid protein is exceedingly high in spinal cord hemangioblastoma. This is in contrast with levels observed in cerebellar hemangioblastoma in which protein is seldom elevated and then only minimally.[7-10]

Vertebral and aortic angiography utilizing subtraction techniques will enable surgeons to see the anatomic ramifications of the malformation so that arterial feeders can be ligated, sparing the normal circulation. Because vascular malformations are often located on the posterior tier of the cord, thoracic myelography should be carried out in both the supine and the prone positions, otherwise the angioma may be missed.[11-13]

Table 2 gives the basic screening program recommended by Neumann et al[14] for patients at risk for von Hippel-Landau syndrome.

Microsurgical removal is the technique of choice for operative treatment of central nervous system hemangioblastomas.[14]

Conclusion

The case history presented here is notable because of the patient's long-term survival and significant recovery after successful removal of multiple hemangiomas.

The author expresses gratitude for their help to Sondralee Goldhammer and Susan Greenwald.

References

1. Cramer F, Kinsey W. The cerebellar hemangioblastoma. Review of fifty-three cases, with special reference to cerebellar cysts. Arch Neurol Psych 1952;67:237-252
2. Cushing H, Bailey P. Hemangiomas of cerebellum and retina (Lindau's disease). Arch Ophthal 1928;57:447
3. Cushing H, Bailey P. Tumors Arising From the Blood Vessels of the Brain. Angiomatous Malformation and Hemangioblastomas. Springfield, Illinois, Charles C. Thomas, 1928
4. Dandy WE. Venous abnormalities and angiomas of the brain. Arch Surg 1928;17:715
5. David M, Thieffry S, Askenasy H. Angioma du bulbe coexistent avec un angiome du cervelet. Ablation. Syndrome d'ataxie postoperatoire. Guerison. Rev Neurol 1936;66:109
6. De Chiro G. Combined retino-cerebellar angiomatosis and deep cervical angiomas. Neurosurg 1957;14:685-7
7. Guillain G, Bertrand Y, Lereboullet Y. Hemangioblastome du systeme nerveaux central a localisation multiples. Rev Neurol 1932;1:432
8. Lindau A. Discussion on vascular tumors of the brain and spinal cord. Proc R Soc Med 1931;24:363-370
9. Lindau A. Studien uber Kleinhirnysten. Bau, Pathogenese und Besiehungen fur angiomatosis retinae. Acta Pathol Microbiol 1926;Suppl 1:129
10. Melmon L, Rosen W. Lindau's disease. Amer J Med 1964;36:595-617
11. Otenasek FJ, Silver MI. Spinal hemangioma (hemangioblastoma) in Lindau's disease. Report of six cases in a single family. J Neurosurg 1961;18:295
12. Silver ML, Hennigar G. Cerebellar hemangioma (hemangioblastoma)—A clinical pathological review of 40 cases. J Neurosurg 1952;35:484-494
13. Wyburn-Mason R. The Vascular Abnormalities and Tumors of the Spinal Cord and Its Membranes. St. Louis, C.V. Mosby Co., 1944
14. Neumann HPH. Basic criteria for clinical diagnosis and genetic counseling in von Hippel-Lindau syndrome. Vasa 1987;16:220-226
15. Levine E, Collins DL, Horton WA et al. CT screening of the abdomen in von Hippel-Lindau disease. AJR 1982; 139:505-510

Branchial Cysts Presenting as Neck Infections

Michael Mellis, MD, Mary Ann Frable, MD, and David L. Mobley, MD
Richmond, Virginia

THE branchial apparatus develops during the second week of fetal life and usually has disappeared by the end of the sixth week. Only the first branchial cleft fails to obliterate, portions of it eventually developing into the external auditory canal. First branchial cleft cysts, appearing either in the preauricular area of posterior to the pinna, account for 8% of all branchial cleft cysts.[1] Second branchial cleft defects account for the majority of branchial defects and are found along the anterior border of the sternocleidomastoideus. Third branchial cleft anomalies are rare and appear lower in the neck along the anterior border of the sternocleidomastoideus and may open into the pyriform sinus. Fourth branchial cleft defects are exceedingly rare.[2]

The cysts are lined with squamous epithelium which desquamates, collects as debris in the lumen of the cyst, and tends gradually to enlarge the cyst. These same epithelial cells can be identified by fine needle aspiration, aiding the clinician in establishing a diagnosis.[3,4] The aspirate may appear much like pus, even in noninflamed cysts; the fluid, however, is usually sterile.[5] Cytological material is usually available for review within 15-20 minutes using the Giemsa stain or several hours using the Papanicolora stain. Diagnoses to be considered with a lateral cervical mass include metastatic tumors, benign tumors, lymphomas, congenital cysts and abscesses.

Branchial anomalies present at any age and without sex predilection. Typically, patients present in childhood and early adulthood following an upper respiratory infection with a neck mass or cyst, which slowly enlarges. Two percent of the cyst or sinus tracts are bilateral. Inflammation may develop with tenderness or abscess. Sinus drainage cutaneously or into the pharynx may occur. Other symptoms include dysphagia and respiratory distress.

Fig. 1. Epithelial cyst wall with epithelial debris and inflammatory cells in the lumen (photomicrograph X200).

The diagnosis of a branchial cleft cyst is straightforward when a child or young adult presents with a cystic mass in the lateral neck area but much more difficult to establish when the initial presentation is an acutely inflamed cervical mass of recent onset. Whether in a child or adult, these cysts are not a common finding. For instance, between January 1968 and September 1989 branchial cleft cysts were diagnosed in only eight patients at the Medical College of Virginia Hospitals. Five of these patients were female and three were male. Six were of adult age. All eight patients had been treated by community physicians for varying lengths of time. All patients had rapid onset of the head and neck mass associated with redness, swelling, and tenderness and were presumed to have abscesses. Three patients underwent incision and drainage, and in one patient the procedure was repeated. Six patients underwent fine needle aspiration. Of note, one patient presented with thrombosis of the carotid artery system secondary to chronic inflammation and infection of the adjacent cyst.

Definitive therapy for branchial anomalies is surgi-

From the Department of Otolaryngology, Medical College of Virginia/Virginia Commonwealth University. Address correspondence to Dr. Frable at Box 115, MCV Station, Richmond VA 23298.

Presented in part as a poster presentation at a meeting of the American Academy of Otolaryngology/Head and Neck Surgery, 24-28 September 1989, New Orleans, Louisiana, and in part as a lecture before the Virginia Society of Otolaryngology/Head and Neck Surgery, 20-22 April 1989, Irvington, Virginia.

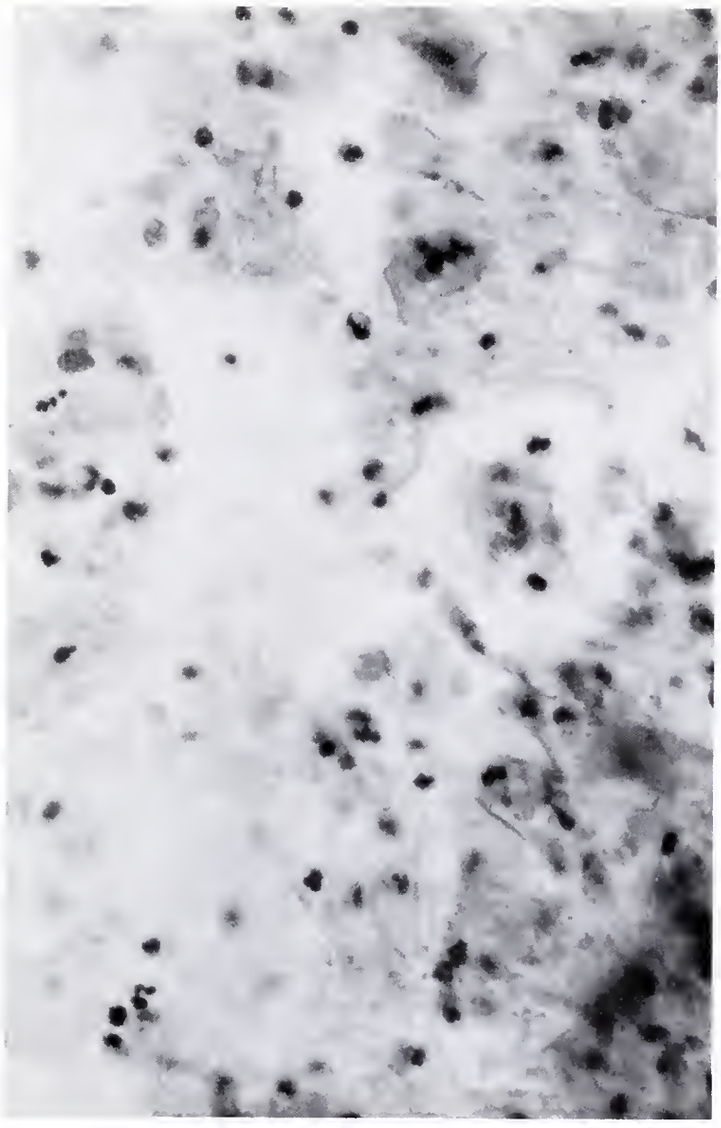


Fig. 2. Squamous epithelial cells benign in appearance (photomicrograph X400).

cal excision. Fine needle aspiration biopsy is often helpful in establishing the diagnosis, particularly if the mode of presentation is unusual. It should be stressed that branchial cleft cysts present not uncommonly as abscesses, and the diagnosis should be considered in any acutely inflamed mass presenting in the head and neck area.

References

1. Finn DG, Buchatter H, Sarti E. et al. First branchial cleft cysts: clinical update. Laryngoscope 1987;97:136-40.
2. Simpson RA. Lateral cervical cysts and fistulas. Laryngoscope 1969;79:30-59.
3. Frable MA, Frable WJ. Thin-needle aspiration biopsy revisited. Laryngoscope 1982;92:1414-18.
4. Engzell V, Zajicek J. Aspiration biopsy and tumors of the neck. I. Aspiration biopsy and cytologic findings in 100 cases of congenital cysts. Acta Cytologica 1980;14:51-7.
5. Orell SR. Manual and Atlas of Fine-Needle Aspiration Cytology. New York, Churchill Livingston, 1986, p 29.

ABSTRACTS

These abstracts were presented at the annual meeting of the Virginia Neurological Society on February 2 in Williamsburg. Dr. Lawrence H. Phillips II, Charlottesville, was program chairman.

Thrombolytic Therapy for Acute Stroke. E. Clarke Haley, Jr., MD, Charlottesville.

Thrombolytic therapy for acute cerebral infarction has received renewed interest in the latter half of the 1980s. The new, recombinantly-produced thrombolytic agents, such as tissue plasminogen activator (rt-PA), hold the potential for being safer than their previously available predecessors, by virtue of their having enhanced activity in the presence of fibrin clot, thereby avoiding systemic fibrinogenolysis. Review of recently published series reporting results of intra-arterial thrombolytic therapy with either urokinase or streptokinase suggests that recanalization of acutely occluded cerebral arteries can be achieved in 50% of cases treated in under 24 hours from the onset of symptoms, and that given that rate of recanalization, about 40% of all the patients that were so treated had substantial neurological recovery. The rate of complicating intracerebral hemorrhage was small, but acceptable. Fortified by this experience, four medical centers (University of Cincinnati, Cornell Medical Center, University of Virginia, and Winchester, Virginia, Medical Center) began an NINDS-funded, dose-escalation safety study of intravenous rt-PA administered very early in the course of acute cerebral infarction in 1987. Preliminary observations in the 74 patients accrued to this study will be discussed. Future plans for a randomized trial will also be presented.

The Ticlopidine Story. John W. Harbison, MD, Richmond.

Ticlopidine hydrochloride is a new potent antiplatelet agent that inhibits the exposure of the GP II b/IIIa surface adhesion receptors of platelets by an unknown mechanism. The effect is both dose and time-related with an onset of activity of 24 to 72 hours. Maximal activity occurs at 3 to 5 days, and effect is still noted 72 hours after a final dose. It is well absorbed orally and extensively metabolized with at least one pharmacologically active metabolite. It is excreted in both urine and feces.

Two recent large multi-centered clinical trials have demonstrated significant success in the reduction of stroke risk. In the Ticlopidine Aspirin Stroke Study (TASS), 3069 patients at 56 North American centers with amaurosis fugax, transient ischemic attacks and minor stroke were randomly assigned to either aspirin 650 mg twice daily or ticlopidine 250 mg twice daily in

a double-blind fashion and followed for 2 to 6 years. Using an intent-to-treat primary analysis, the rates of fatal and non-fatal stroke at 3 years were 10% for ticlopidine and 13% for aspirin, a 21% risk reduction ($P = 0.024$). Patients with recent thromboembolic stroke were studied in a randomized, double-blind, placebo-controlled trial of ticlopidine assessing the rate of reduction of recurrent stroke, myocardial infarction or vascular death. The Canadian-American Ticlopidine Study (CATS) entered 1072 patients at 25 North American centers and followed them for up to 3 years. With primary analysis as efficacy, the event rate per year for stroke, MI or vascular death considered together was 15.3% in the placebo group and 10.8% in the ticlopidine group, a risk reduction of 30.2% ($P = 0.006$). The intent-to-treat analysis revealed a risk reduction of 23.3% ($P = 0.020$). Ticlopidine was beneficial in both men and women in both studies. Adverse drug reactions included neutropenia (severe in about 1% of cases), skin rash and diarrhea (severe in 2% of cases each). All were reversible. Both studies revealed benefit from ticlopidine in stroke risk reduction.

Calcium Channel Blockers in the Treatment of Stroke, Subarachnoid Hemorrhage and Migraine. Robert J. DeLorenzo, MD, Richmond.

Calcium is a major second messenger that signals neurotransmitter release and numerous neurochemical processes in the brain, blood vessels and numerous tissues. Because of calcium's universal importance as a second messenger, significant research has been directed at understanding how calcium enters cells and regulates metabolism. Calcium entry into cells has been implicated in regulating numerous neurological conditions. A current theory of one of the major causes of ischemic brain injury during stroke is the accumulation of excessive calcium within neurons. In subarachnoid hemorrhage, calcium can accumulate around the endothelium and lead to vasospasm. Migraine, another important neurological entity, is believed to be caused by spasms in the cerebral blood supply. Calcium entry into the muscles controlling vascular contraction has been implicated in muscle spasms that occur during migraine. Thus, the use of calcium channel blockers to prevent calcium entry suddenly has emerged on the clinical scene for treating conditions where calcium may be causing pathology. At the present time, protocols are being initiated to study calcium channel blockers for the treatment of stroke, subarachnoid hemorrhage and migraine. Significant clinical data is already available on the benefits on calcium channel blockers for the treatment of subarachnoid hemorrhage and migraine. The role of calcium blockers in stroke is still premature but laboratory research as well as human studies suggest that this may also be of significant benefit in decreasing the morbidity and mortality associated with stroke.

The purpose of this lecture is to provide information about the types of calcium channels and how their regulation might have implications to clinical disease. The material provides a synopsis of what is currently known about calcium channels and calcium metabolism once calcium enters the cell. The relationship of the calcium system to the treatment of stroke, subarachnoid hemorrhage and migraine will be presented in significant detail. It is hoped that this information will be helpful to the clinician in evaluating future research and treatment protocols that will be coming out in the literature utilizing calcium channel blockers or calcium metabolism inhibitors in treating neurological disease.

New Approaches for Management of Stroke. N.F. Kassell, MD, Charlottesville.

Recently, there have been remarkable advances in the management of patients with intracranial aneurysms and arteriovenous malformations and occlusive cerebrovascular disease. The diagnosis of aneurysms will soon be facilitated by perfection of magnetic resonance angiography. Unruptured aneurysms should be corrected if they are larger than 5–7 mm in diameter. Rebleeding and vasospasm are the leading causes of death and disability after aneurysmal subarachnoid hemorrhage. The peak of rebleeding is within the first 24 hours following the initial hemorrhage and is 75% fatal. With modern neurosurgical and interventional angiographic techniques, most aneurysms can be obliterated, regardless of size or location. Surgery should be performed as soon as possible to decrease the possibilities of rebleeding. Accordingly, early diagnosis and referral of patients with ruptured aneurysms to neurosurgical attention is essential to optimize outcome. Transcranial Doppler is a new adjunct for diagnosing cerebral vasospasm. Vasospasm can be prevented by early surgery with removal of clot from the subarachnoid space at the time of aneurysm clipping. Calcium channel blocking agents (nimodipine and nicardipine) and the 21 amino steroids show promise for managing vasospasm. Spastic arteries can be dilated with transluminal angioplasty. Ischemic deficits from vasospasm can be reversed with induced systemic arterial hypertension and hypervolemia.

The incidence of arteriovenous malformations AVMs has been increasing as a result of CT and MR scanning. Most AVMs can now be safely treated with microsurgery, radiosurgery, embolization, or a combination of these modalities. Surgical removal of arteriovenous malformations, even large lesions in eloquent regions of brain, has been markedly facilitated by the operating microscope which assists in identifying feeding arteries and draining veins and maintaining the plane of cleavage of the malformation from the

Ciguatera Fish Poisoning: An Outbreak Associated With Fish Caught From North Carolina Coastal Waters. Peter D. Morris, MD, Douglas S. Campbell, MD, and John I. Freeman, DVM, Raleigh, North Carolina.

Ten persons who had eaten a seafood meal in North Carolina had gastrointestinal and neurologic symptoms suggestive of ciguatera fish poisoning. In five persons, the neurologic morbidity lasted 30 days or longer. The meal included barracuda, dolphin fish (mahimahi), and yellowfin tuna, all of which were caught in North Carolina coastal waters. Analysis of food-specific attack rates implicated the barracuda as the probable cause of the outbreak. We believe this is the first suspected or confirmed report of ciguatera fish poisoning associated with consumption of fish harvested from mainland US coastal waters outside of Florida. Physicians treating patients with a syndrome resembling ciguatera fish poisoning should inquire about consumption of fish not only from areas where the disease is endemic but also from the southeastern US. South Med J 1990;83:379-382

brain, and with new bipolar cautery for coagulating vessels and shrinking the malformation. Stereotactic radiosurgery with the Gamma knife, utilizing a single high dose of precisely focused radiation from 201 intersecting beams of cobalt 60 is an effective means for non-invasively obliterating AVMs less than 30 mm in diameter, with results equivalent to open surgery. AVMs too large for steriotactic radiosurgery can be partially embolized, thus rendering them within the size which can be treated with the Gamma Knife. The feeding arteries and the nidus of AVMs can be obliterated with detachable balloons, particulate emboli, acrylate glues, and microcoils, but embolization has not proven successful in totally obliterating most AVMs. However, it can be used to advantage preoperatively to facilitate resection of AVMs as well as to reduce the size of malformations, allowing them to be treated with the Gamma knife.

Angioplasty of the carotid and vertebral arteries in the neck is in its infancy but may prove to be a viable alternative to surgery for use in those patients in whom endarterectomy is contraindicated for technical reasons or medical risks.

Sporotrichoid Atypical Mycobacteriosis. Kathleen Y. Sawada, MD, Richmond.

A 38-year-old white male asthmatic developed a 1.5-cm well-circumscribed nontender nodule at the base of his thumb. The nodule gradually developed serous drainage which then became purulent. He also noted the onset of five small erythematous less well-defined nodules extending proximally up his left arm. There were no systemic symptoms. The patient recollected an injury at the primary site when he was cleaning his sailboat a week or two prior to the appearance of the first nodule. Medications included prednisone at a dose of 20 mg a day. A skin biopsy showed findings consistent with atypical mycobacterial infection of the skin, including the presence of scattered acid-fast positive organisms with a beaded appearance. Culture eventually identified mycobacterium marinum. Treatment with rifampin and ethambutol was initiated with early improvement in the nodules.

Mycobacterium marinum is the most common of the mycobacteria to produce primary inoculation skin infections. Single or multiple lesions may be present. There is commonly a history of contact with water such as swimming pools or fish tanks. Medical treatment consists of antituberculous drugs, tetracycline, minocycline, trimethoprim-sulfamethoxiazole. For small localized lesions, surgical excision is appropriate. *Presented before the Virginia Dermatological Society on November 12, 1989, in Richmond.*

Cervical Epidural Abscess. Daniel Edney, MD, and W. Michael Scheld, MD, *Charlottesville.*

Spinal epidural abscesses are uncommon, but cervical epidural abscesses are indeed a rare entity. We present a case which typifies the presentation of an epidural abscess.

A 56-year-old black female with a history of alcohol abuse presented with a 3-day history of right-sided neck and shoulder pain after sustaining a fall. Surgical evaluation was unrevealing with no neck instability noted. A fever of 39°C was documented and she was admitted for further evaluation as she refused lumbar puncture. Within hours of admission, she developed bilateral arm weakness and sustained a respiratory arrest requiring endotracheal intubation. CT-myelogram demonstrated an epidural abscess from C2-C5 with complete block at C3. Surgical drainage revealed a large fluid collection anteriorly with abscess and blood cultures growing *S. aureus*. The source was a sinus tract draining a site of chronic osteomyelitis on the plantar surface of the right great toe.

The mechanism of neurologic impairment is thought to be both mechanical and ischemic secondary to compression and vascular thrombosis. Prognosis for recovery relates directly to time until diagnosis and institution of appropriate therapy (Neurology 1989; 37:1747, N Eng J Med 1975;293:463, others). *Presented before the Virginia Chapter, American College of Physicians, and the Virginia Society of Internal Medicine on March 24, 1990.*

Think of it as a health care library for your patients.

We know every one of your patients is unique. With different needs. . . different treatments. And very different questions about their health care needs.

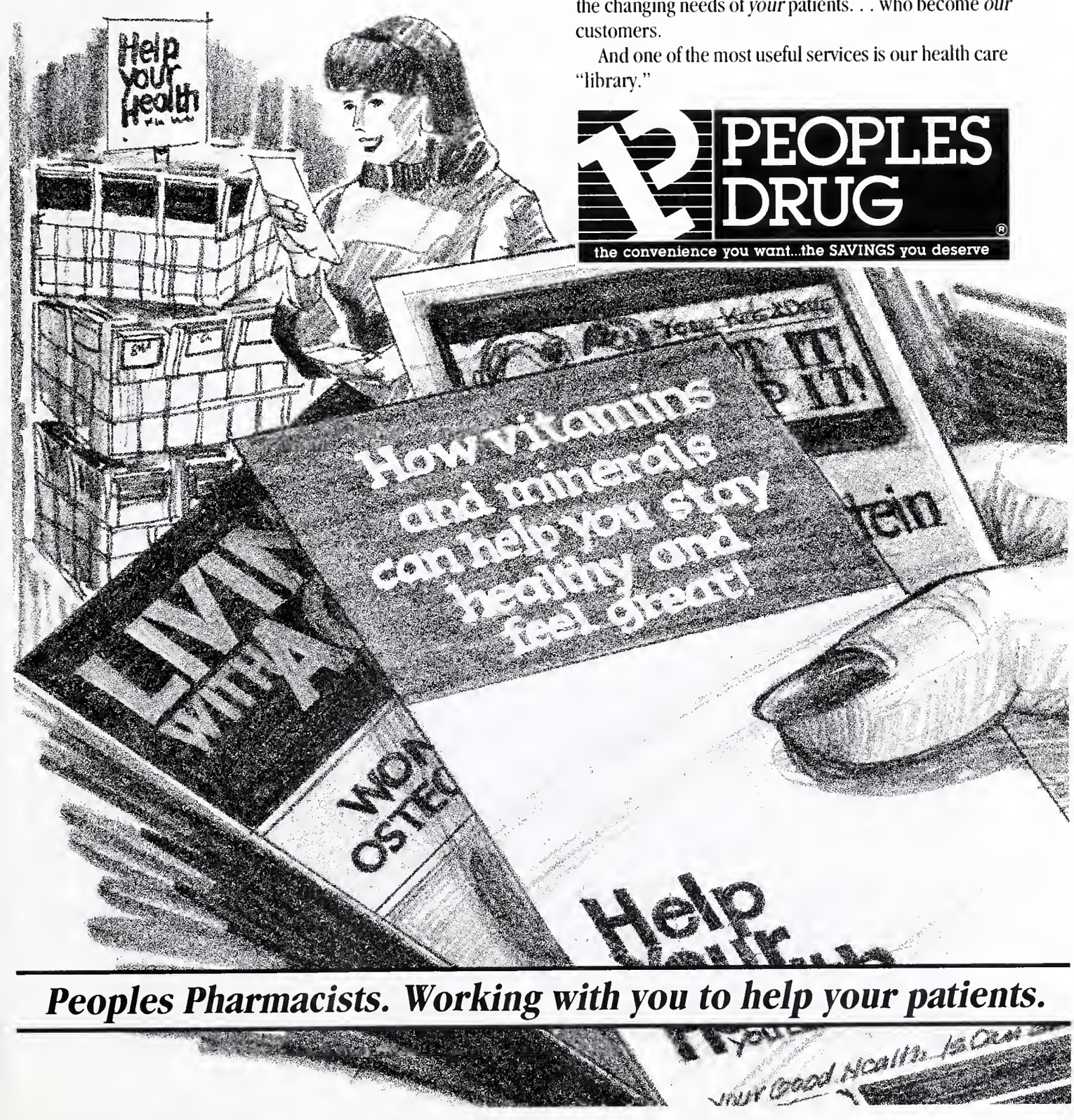
So we publish a broad spectrum of health care pamphlets to meet the informational needs of your patients. They're all free and your patients can pick them up at the pharmacy counter of any Peoples Drug Store. They include series such as "Your Kids & Drugs—Spot It—Stop It," "Living With Aging," and "Help Your Health—You Can, We Can." Plus individual pamphlets on Rabies, Poison, Insect Stings, Immunization, and many more topics.

It's just another example of how—for over 80 years—Peoples Drug has served its customers with unmatched care and professionalism. Today, all our services reflect our continuing commitment to meeting the changing needs of *your* patients. . . who become *our* customers.

And one of the most useful services is our health care "library."

PEOPLES DRUG®

the convenience you want...the SAVINGS you deserve



Peoples Pharmacists. Working with you to help your patients.

VOL. I. APRIL, 1874. No. 1.

VIRGINIA
Medical Monthly.

LANDON B. EDWARDS, M. D.,

Member of the Va. State Board of Health, Recording Secretary Medical Society of Virginia, &c.,

Editor and Proprietor.

EDO UT PROSIM.

CONTENTS.

ORIGINAL COMMUNICATIONS:

ART. I.—Sponge Tent in Menorrhagi.. By J. H. CLAIBORNE, A. M., M. D..... 1

ART. II.—Drainage in Obstinate Chronic Inflammation of the Bladder. By HUNTER MCGUIRE, M.D..... 6

ART. III.—Oxygen Gas as a Remedy in Disease. By J. L. CABELL, A. M., M. D., LL.D 9

ART. IV.—(1) Acute Lead Poisoning—Recovery. (2) Traumatic Tetanus in which large doses of Calabar Bean were used—Remarks. By C. TOMPKINS, M.D..... 14

ANALYSES, SELECTIONS, &C.:

A Marsh Plant supposed to be kindred to the Gemiasma of Salisbury, with a consideration of its Genetic Relations to Malarial Diseases..... 19

Hypodermic Injection of Quinine..... 25

Protection of Hypodermic Solutions from Change by Keeping..... 27

Siamese Twins..... 30

Gelseminum 33

Medico-Chirurgical Lessons of the late War from Southern standpoints..... 35

ANALYSES, &C. (Continued).

Aphasia without Paralysis—New Galvano-Caustic Battery..... 38

Mint as an Anti-Galactagogue—Phytolacca Decandra—Diabetes..... 39

Bromide of Potassium as a Prophylactic to Mercurial Ptyalism—Preservation of Vaccine Crusts—Inoffensive Sponge Tents—Esmarch's Bloodless Operation—Chloroform..... 41

BOOK-NOTICES, &C..... 41

PROCEEDINGS OF SOCIETIES:

Richmond Academy of Medicine..... 50

New York Academy of Medicine..... 52

New York State Medical Society..... 53

EDITORIAL:

Salutatory..... 54

Virginia State Board of Health..... 55

American Medical Association..... 57

Medical College of Virginia..... 59

Siamese Twins..... 61

NOTES, MISCELLANY, &C..... 62

OBITUARY RECORD..... 63

VIRGINIA MORTUARY STATISTICS..... 64

Subscription, $2.00 per Annum, in Advance. Single Copy, 25 Cents.

RICHMOND, VA.

VIRGINIA MEDICAL

Now a Quarterly

BEGINNING with the July issue, VIRGINIA MEDICAL will be published quarterly. At the same time, the Medical Society of Virginia's service-oriented newsletter, now published sporadically, will be increased in size and frequency.

The decision to make this change was made by the Medical Society of Virginia Executive Committee under the leadership of Dr. William H. Barney, President. There was in April unanimous approval by the Medical Society of Virginia Council. There are cogent reasons for the change.

First, present-day print technology permits far swifter dissemination of information than conventional magazine production, which requires a six-week lead time. With the newsletter it will be possible to more promptly disseminate information of news and events of importance to physicians.

Second, scientific manuscripts have dwindled steadily in number during the past decade. No longer are 12 issues a year needed to publish the contributions of Virginia physicians.

The other major factor is cost. The conventional journal format has risen dramatically in cost over the past decade, not only in print and paper, but in postage.

As for the new VIRGINIA MEDICAL QUARTERLY, readers should not anticipate a major change. There will be a new cover, reflecting the change in name. Scientific articles will be continued and manuscripts are solicited. As before, welcome is continued for contributions dealing with the art as well as the economics of medicine. The listing of obituaries and the Who's Who column will continue.

Onward and upward. E.L.K., JR.

Thanks for a Super Year

THE 1990 General Assembly provided the MSV lobbying team with the most exciting and busiest session I can remember. The legislative team deserves our highest praise and thanks for a super job. Its members dealt directly with over 50 bills, reports, regulations, and the budget. The March 1990 *MSV Legislative Update* listed 26 items, up from 16 for March 1989.

At least ten positive bills were passed, including establishment of peer review standards under the Insurance Commissioner; improved definition of the Injured Infant Act, as described elsewhere in this issue; exclusion of certain retirement benefits from creditors' claims; broader immunity from liability for HIV infection reporting; nonsmoking areas in indoor public places; addtional latitude for the relief of intractable pain. Three bills constructively attacked the combined problems of the un- and under-insured, child health, indigent care and rural health.

This pro-active legislation was all initiated by, contributed to, and/or supported by The Medical Society of Virginia. The Legislative Committee met five times

during the session, and some of its members testified before committees. MSV members owe a great dealt to Chairman Ken Tuck and those who donated their time to testify, contact legislators and make telephone calls. Their efforts were a much needed part of a significantly successful year.

H. C. Alexander III, MD

Collision Course

The private practice of medicine is on a collision course with the liberals in Congress who espouse an egalitarian approach to the delivery of medical care. They do so with the populist appeal that health care in the United States is at a low watermark. Their solution is to bring about some form of national health insurance and with it federal controls totally ignoring the importance of the free market and the value of competition.

Since the 1930s, beginning with the infamous Wagner-Murray-Dingell bills, American medicine has been continually under siege by liberals in Congress and in academia seeking the lowest common denominator by which medical care will be delivered to the American public. Never mind that the zeal for total equality will ultimately lead to the destruction of the world's best system of medical care; all that is needed, so they say, is to provide for the estimated 37 million Americans without some form of insurance. Their myopia is blinding.

Unless and until individual physicians, irrespective of speciality, unite to protest the egregious addition to title XVIII of the Social Security Act, the fee-for-service practice of medicine will continue on the slippery slope to oblivion. Where better for zealots to begin than with Medicare? This they did by slipping the new section entitled "Payment for Physicians' Services" into the Omnibus Budget Reconciliation Act of 1989 (PL 101-239, Dec. 19, 1989).

This new section provides the Secretary of Health and Human Services with extraordinary powers over the practice of medicine as it applies to the care of Medicare-eligible individuals. The implementation date is 1992. There remains time to influence individual senators and congressmen that the relative value approach to establishing fees is not the American way. Comparable worth as a principle has no place in the free enterprise system of American medicine. What could be worse?

Craftily contained in this section of PL101-239, which did not enjoy wide publicity or extensive testimony, is a not-so-veiled threat of Volume Performance Standards. This has the eerie sound of rationing somewhere after 1992! This, coupled with the other damaging parts of the law, is serious business. How can any physician remain silent when medicine is under such a frontal attack? And what about those who depend on Medicare?

In November 1989 Congress had to admit defeat; it repealed the Medicare Catastrophic Health Care Act passed the previous year. Because of grass roots efforts, senior citizens rebelled and their voices were heard in Congress. Once seniors become aware of the total impact of the 1989 revision to Title XVIII they will rise again in protest that they could well be victims of a medical/surgical rationing plan. An effort is now underway to let senior citizens know that, once again, their senators and representatives have made them targets and hostages to a deliberate effort by liberals in Congress to harness the medical profession and bend the profession to their liberal will.

The Department of Health and Human Services and its Health Care Financing Administration in a report to Congress titled "Medicare Physician Payment" stated (item 6 of the conclusions): "Nonetheless, because the changes in payment that would result under the fee schedule are far more extensive than previous changes, there simply is no reliable basis for predicting the response of physicians either in terms of willingness to treat Medicare patients or willingness to accept assignment. This uncertainty argues for a cautious approach toward fee schedule implementation."

Item 8 of the report's conclusions states: "Although initial results are encouraging, a resource-based fee schedule is not yet ready for use as the exclusive basis for determining all Medicare payments."

The report to Congress from HHS and HCFA is a telling indictment that implementation is fraught with difficulties. This says there is time for grass root protests by physicians and by their Medicare-eligible patients. Without such protests all physicians and all elderly patients will be the losers. With that outcome all Americans will wake up to realize that the health care they have relied on will evaporate into the system "enjoyed" by socialist societies with long waits for care and rationing of needed procedures.

The remark made by the Medical Society of Virginia's President, William H. Barney, MD, in his inaugural address was never more apt: "I am convinced that we are closer now to national health insurance than we have been in the 45 years that I have been in medicine. . . ." He was and is so right. Time is short and action is an imperative. Now.

Bedford H. Berrey, MD

4431 Old Fox Trail
Midlothian VA 23112

VIRGINIA MEDICAL OBITUARY

Memoir of Levi Hulley 1914-1989

By Thomas W. Murrell, Jr., MD, Clarry C. Trice, MD, and William R. Hill, MD

Levi Woodbry Hulley, Jr., MD, died in Richmond on December 10, 1989.

Dr. Hulley's early life was spent on Staten Island, New York. He matriculated at the University of Virginia, where he received his BS degree and graduated from the School of Medicine in 1939. After graduation he served internships at the Jersey City Medical Center and the Margaret Hague Maternity Hospital. Much later, in the 1960s, he took courses in aviation medicine at the College of Physicians and Surgeons (Columbia) and Georgetown University School of Medicine.

After serving six months at the Radford Ordinance Works in 1941 he entered general practice in Laurel, Maryland, for one year and then continued practice at Palmyra, Virginia, until 1950, when he moved to Richmond to practice general and industrial medicine. His principle hospital affiliation was St. Elizabeth's Hospital Corporation, where he served as president, chief of staff and director between 1965-1972.

He was a medical advisor to the Industrial Commission of Virginia 1954-1969 and a medical examiner for the Federal Aviation Administration from 1960-1972. Dr. Hulley was also a member of the staff of the A.D. Williams Memorial Clinic at the Medical College of Virginia from 1950-1959.

When in private practice Dr. Hulley was very interested and involved in the Virginia Academy of Family Physicians, beginning in 1951. He served as director, president, treasurer and was a member of a number of its committees. He was also a member of the American Academy of Family Physicians and the Richmond Academy of General Practice.

His involvement in industrial medical practice led him to membership in the Virginia Industrial Medical Society (director, secretary-treasurer 1967-1969), the American Occupational Medical Association, and the Southern Association of Workmen's Compensation Administrators. He was a member of the Richmond Academy of Medicine and The Medical Society of Virginia, serving on multiple committees of both of these organizations, and of the American Medical Association.

In September 1969 Dr. Hulley became medical director of Blue Cross-Blue Shield of Virginia. Because Levi had been engaged in the practice of clinical medicine this appointment was an excellent choice. During his tenure he exerted maximum effort to be absolutely fair with all disputed claims which were brought to his attention, whether from subscribers or physicians. As an executive of the company he took strong positions against any proposal from without or within which would result in unfair control of the practice of medicine. A number of unfortunate changes in the medical environment occurred after he retired, but he knew he had done his best to stem the tide.

Dr. Hulley was a communicant of All Saints Episcopal Church.

He is survived by his wife, Frances Digges Hulley, one daughter, Dr. Joan Frances Hulley Liverman, and two grandchildren, Eric Louis Hulley Liverman and Astrid Marguerite Bybee Liverman.

Levi Hulley was a man of high ethical standards and a gentleman who will long be remembered in Virginia.

• **John Elwood Collier, MD,** Richmond area physician for 53 years; Medical College of Virginia, 1931; age 83; died April 1, 1990.

• **William Rowland Hill, MD,** Richmond gynecologist and surgeon; University of Virginia School of Medicine, 1934; age 81; died April 10, 1990. Dr. Hill, who retired in January of this year, had been president of The Medical Society of Virginia, the Richmond Academy of Medicine, and the State Board of Health.

• **Lockhart Bemiss McGuire, MD,** Charlottesville, cardiologist and professor of medicine at his alma mater, the University of Virginia (Class of 1957); age 55; died April 29, 1990.

• **Rees Morgan, MD,** captain United States Navy Reserve retired, Ft. Lauderdale, Florida; University of Virginia School of Medicine, 1924; age 89; died February 17, 1990. Before retiring to Florida in 1958, Dr. Morgan practiced obstetrics/gynecology in Roanoke.

• **Eugene Bowie Shepherd, MD,** retired Richmond internist; Medical College of Virginia, 1935; age 82; died April 2, 1990.

HERE'S ONE CASE OUR ADDICTION SPECIALISTS RARELY SEE.

You could probably say we've seen it all at the University Center for Addictive Behavior. Our patients range from the abuser to the severely addicted; from the adolescent to the older adult.

But even with our diverse caseload, you'll hardly ever see anyone being admitted to the hospital. Because we help patients overcome their problems without hospitalization, through comprehensive programs, which are conducted on an outpatient basis. Even chemical withdrawal can be done without the patient being admitted.

Of course, sometimes a patient will need to be hospitalized. We can arrange to do so on a short-term basis, until those patients are ready for one of UCAB's out-patient programs, exclusively staffed by MCV faculty.

If you know someone who needs addictions treatment, no matter how slight or how severe their problem, call UCAB. We're here to help stop their addiction. Case closed.

M C V
UCAB
HOSPITALS

Conveniently located in the West End. The Forum Executive Center, 10124 West Broad Street, Glen Allen, Virginia, (804) 662-7172

DO NEW MEDICAL MALPRACTICE CARRIERS MAKE YOU NERVOUS?

Some medical malpractice carriers offer a low price the first couple of years. After that, who knows?

We've been independent brokers for more than forty years and can offer competitive policies and premiums. We're not limited to an endorsed policy or exclusives required by many insurance carriers.

Find out about some **"A+"** companies who have established a track record. Save yourself some money.

We can advise you on the *best* policy for all your needs—from the *best* company at the *best* price. Frankly, we can handle all your professional and personal insurance needs, from office packages to auto coverages.

Call Clements and Company today for an "independent's approach" to buying medical malpractice insurance.

INSURANCE BROKERS WORLDWIDE

CLEMENTS AND COMPANY

Specialist in Medical Malpractice Insurance

Telephone: (202)872-0060 **Fax:** (202)466-9064

Telex: 64514 **Cable:** CLEMENTS/WASHINGTON

1730 K Street, NW, Suite 701, Washington, DC 20006

NEW MSV MEMBERS

Albemarle County Medical Society

Julie L. Blommel, MD, Obstetrics/Gynecology, 1820 Steeplechase Run, Charlottesville VA 22901

Louise O. Wensel, Psychiatry, 11 Orchard Road, Charlottesville, VA 22901

Valerie A. Brookeman, MD, Diagnostic Radiology, 1634 St. Annes Road, Charlottesville VA 22901

Alexandria Medical Society

Carlos P. Artiles, MD, Radiology, 2853 Duke Street, Alexandria VA 22314

Tobin S. Naidort, MD, Gastroenterology, 2817 Duke Street, Alexandria VA 22314

Rhonda R. Stewart, MD, Diagnostic Radiology, 2853 Duke Street, Alexandria VA 22314

Culpeper County Medical Society

Peter E. Godfrey, MD, Obstetrics/Gynecology, 633 Sunset Lane, Culpeper VA 22701

Fairfax County Medical Society

Michael B. Price, MD, Internal Medicine, 6845 Elm Street, McLean VA 22101

Mid-Tidewater Medical Society

George V. Frankhouser, Jr., MD, General Surgery, PO Box 2098, Tappahannock VA 22560

Norfolk Academy of Medicine

Lawrence J. Aladj, MD, Anesthesiology, 503 Medical Tower, Norfolk VA 23507

Wayne Y. Bergen, MD, Anesthesiology, 207-B 82nd Street, Virginia Beach VA 23451

Robert C. Bernstein, MD, Cardiology, 844 Kempsville Road, Norfolk VA 23502

Robert G. Brzyski, MD, Reproductive Endocrinology, 825 Fairfax Avenue, Norfolk VA 23507

William P. Bundschuh, MD, Anesthesiology, 503 Medical Tower, Norfolk VA 23507

J. Abbott Byrd III, MD, Orthopedic Surgery, 844 Kempsville Road, Norfolk VA 23502

John J. Cook, MD, Anesthesiology, 503 Medical Tower, Norfolk VA 23507

Charles L. Etheridge, MD, Anesthesiology, 6010 Carroll Place, Norfolk VA 23508

Lloyd J. Faul, Jr., MD, Anesthesiology, 3615 Atlantic Avenue, Virginia Beach VA 23451

Robert J. Goldstein, MD, Anesthesiology, 503 Medical Tower, Norfolk VA 23507

Steven C. Johnson, MD, Anesthesiology, 503 Medical Tower, Norfolk VA 23507

Henry Suh Lim, MD, Anesthesiology, 8972 River Crescent Drive, Suffolk VA 23433

Jon M. McGruder, MD, Anesthesiology, 1848 Windy Ridge Point, Virginia Beach VA 23454

James B. Mueller, MD, Anesthesiology, 1119 Botetourt Gardens, Norfolk VA 23507

John E. Olenczak, MD, Anesthesiology, 503 Medical Tower, Norfolk VA 23507

Paul V. Renda, MD, Anesthesiology, 503 Medical Tower, Norfolk VA 23507

Charles A. Ward, MD, Anesthesiology, 503 Medical Tower, Norfolk VA 23507

Northampton County Medical Society

William J. Somers, MD, Urology, Box 651, Painter VA 23420

Portsmouth Academy of Medicine

Frederick J. Witt, MD, Gynecology, 3108 Tyre Neck Road, Portsmouth VA 23703

Richmond Academy of Medicine

Michael R. Perlman, MD, Otolaryngology, 1423 Johnston Willis Drive, Richmond VA 23235

Rockingham County Medical Society

Philip W. Day, MD, Internal Medicine, 1937 Medical Avenue, Harrisonburg VA 22801

Roanoke Valley Academy of Medicine

John A. Feldenzer, MD, Neurosurgery, 2601 Franklin Road SW, Roanoke VA 24014

Joseph G. Gunselman, MD, Anesthesiology, PO Box 13306, Roanoke VA 24014

Geoffrey T. Harter, MD, Otolaryngology, 201 McClanahan Street, Roanoke VA 24014

Earl Mark Watts, MD, Family Practice, 204 South Maple Street, Vinton VA 24179

J. Byard Yoder, MD, Family Practice, 5501 Williamson Road, Roanoke VA 24012

Southwestern Virginia Medical Society

Nancy D. Holland, MD, Diagnostic Radiology, 199 Hospital Drive, Galax VA 24333

J. Frederick Hyduke, MD, Anesthesiology, 1233 Collins Drive, Pulaski VA 24301

Tri-County Medical Society

David M. Eich, MD, Cardiology, 2000 Meade Parkway, Suffolk VA 23434

Virginia Beach Medical Society

Robert G. Burney, MD, Anesthesiology, 1000 First Colonial Road, Virginia Beach VA 23454

Williamsburg-James City County Medical Society

Lewis H. Curd, Jr., MD, Pediatrics, 1162 Professional Drive, Williamsburg VA 23185

John C. Mincks, MD, Internal Medicine, 1115 Old Colony Lane, Williamsburg VA 23185

continued over

Residents

Alexander Andriuk, MD, Internal Medicine, 9684 Lindenbrook Drive, Fairfax VA 22031

Christopher W. Asuncion, MD, Family Practice, 706 Stockley Garden Road, Norfolk VA 23507

Philip J. Balestrieri, MD, Anesthesiology, 604 North Wakefield Street, Arlington VA 22203

James S. Barna, MD, Otolaryngology, 646 Elgin Terrace, Richmond VA 23225

Scott S. Berman, MD, General Surgery, 1456 Goose Landing, Virginia Beach VA 23451

David A. Bettinger, MD, General Surgery, 600 West 31st Street, Richmond VA 23225

Virginia A. Blanks, MD, Family Practice, 241 Windingway Road, Lynchburg VA 24502

John W. Bolen, Jr., MD, Radiology, 4280 Pine Grove, Earlysville VA 22936

Alberto A. Borges, MD, Hematology, 2637 North Florida Street, Arlington VA 22207

James E. Boyle, MD, Internal Medicine, 3724 King and King Drive, Richmond VA 23223

Steven C. Brandon, MD, Family Practice, 513 Riverland Road, Roanoke VA 24014

James P. Brodeur, MD, Rheumatology, 5915 Edgewood Road, Mechanicsville VA 23111

Michael D. Brown, MD, Child Psychiatry, 410 South Virginia Avenue, Falls Church VA 22046

Paul F. Brown, MD, Child Neurology, 8506 Hanford Drive, Richmond VA 23229

John J. Bunker, MD, Anesthesiology, 104 West Franklin Street, Richmond VA 23220

Lois P. Buschbacher, MD, Physical Medicine & Rehabilitation, 9205 Timbers Edge Court, Glen Allen VA 23060

Sharon S. Camden, MD, Dermatology, 511 West 26th Street, Richmond VA 23225

Christopher Cantilena, MD, Anesthesiology, 4435 Pepeer Ridge Court, Chesapeake VA 23321

Juan J. Carmona, MD, Psychiatry, 2712 Laurelton Place, Richmond VA 23228

Stephen L. Cornwell, MD, Family Practice, 2426 David Avenue, Alexandria VA 22302

Sheila E. Carroll, MD, Orthopedics, 2295 Cartbridge Road, Falls Church VA 22043

Elizabeth L. Ciurlik, MD, Pediatrics, 3423 Spendthrift Drive, Richmond VA 23294

Jorge A. Cortina, MD, Psychiatry, 1475 Gray Stone Court, Charlottesville VA 22901

Eric P. Cote, MD, Public Health, 405 Allen Drive, Charlottesville VA 22903

Martha L. D'Ambrosio, MD, Public Health, 405 Allen Drive, Charlottesville VA 22903

Teddy V. Dela Cruz, MD, Pediatrics, 612 H Fairfax Avenue, Norfolk VA 23507

Dean S. Cunningham, MD, Obstetrics/Gynecology, 4448 Clemsford Drive, Virginia Beach VA 23456

Laura N. Dabinett, MD, Obstetrics/Gynecology, 609 Big Oak Road, Charlottesville VA 22901

Joseph M. Damron, Jr., MD, Pediatrics, 1870 Amherst Street, Winchester VA 22601

Pradip K. Das, MD, Physical/Rehabilitation Medicine, 11401 Dunbrook Road, Richmond VA 23235

Philip A. Dawson, MD, Pediatrics, 1117 S. Quincy Street, Arlington VA 22204

David R. Diduch, MD, Orthopedic Surgery, 1607 Dublin Road, Charlottesville VA 22903

Donald E. Dingus II, MD, Family Practice, 6856 Mason Knob Trail, Roanoke VA 24018

Anthony J. Distasio, MD, Orthopedic Surgery, 4152 Stonebridge Landing, Chesapeake VA 23321

Denise M. Dixon, MD, Internal Medicine, 6175 Edward Street, #304, Norfolk VA 23513

David B. Drake, MD, Plastic Surgery, 326 Glade Lane, Charlottesville VA 22901

John J. Dreyzehener, MD, General Practice, 501 Slaters Lane, Alexandria VA 22314

Paul F. Duckworth, Jr., MD, Gastroenterology, 4622 Leonard Parkway, Richmond VA 23226

Cornelius M. Dyke, MD, Thoracic Surgery, 9501 University Boulevard, Richmond VA 23229

Michael C. Edelstein, MD, Reproductive Endocrinology, 613 Whispering Willow Court, Virginia Beach VA 23462

Mona L. Ellis, MD, Family Practice, 5904 Mount Eagle Drive, Alexandria VA 22303

R. Bruce Evans, MD, Family Practice, 1149 Westcreek Drive, Richmond VA 23236

Randall K. Falls, MD, Obstetrics/Gynecology, 1345 Woodbine Street SE, Roanoke VA 24014

Thomas L. Fariss, MD, Internal Medicine, 22407 Arlington Boulevard, Arlington VA 22201

Richard L. Feinberg, MD, Vascular Surgery, 300 Yarmouth Street, Norfolk VA 23510

John G. Fisher, MD, Psychiatry, 11100 Surry Road, Chester VA 23831

Lisa L. Friend, MD, Public Health, 719 Boulder Springs Drive, Richmond VA 23225

Bryan E. Fuhs, MD, Cardiology, 7547 Turf Lane, Richmond VA 23225

Elizabeth A. Garreau, MD, Obstetrics/Gynecology, 5400 North Morgan Street, Alexandria VA 22312

Cynthia L. Gauss, MD, Psychiatry, 3324 Highland Lane, Fairfax VA 22031

Lawrence E. Gelber, MD, Allergy/Clinical Immunology, 117 Turtle Creek Road, Charlottesville VA 22901

Timothy B. Gilbert, MD, Anesthesiology, 2015 Key Boulevard, #604, Arlington VA 22201

Eleanor Glaspy-Benton, MD, Obstetrics/Gynecology, 1535 Honey Grove Drive, Richmond VA 23229

Susan K. Glocheski, MD, Psychiatry, 7000 West Franklin Street, Richmond VA 23226

Richard L. Griffith, MD, Internal Medicine, 121-A Westerly Avenue, Charlottesville VA 22903

Charles M. Hahn, MD, Anesthesiology, 151 Scarborough Place, Charlottesville VA 22901

continued page 273

FreeVideo!

To help you automate your practice.

If you are considering automating your practice within the next 12 months, I will send you a free video tape, which will enable you to learn the major factors contributing to the success or failure of a computer system in a medical practice. This tape gives you the opportunity to draw on the experience of other practices that have successfully automated. And you can do this in the comfort of your home or office with a minimal time investment.

Mr. Ami Elis
President
Elcomp Systems, Inc.

FLEXIBLE™ PACKAGE
by ELCOMP®
Elcomp Systems, Inc.

Foster Plaza VI, 681 Andersen Drive, Pittsburgh, PA 15220
1-800-441-8386

With a local office in Richmond.

IBM Business Partner
Authorized Industry Remarketer

Yes, please send me your free video.

Practice name _____

Address _____

City, State, Zip _____

Phone _____

Specialty _____

Number of Physicians _____

PUT YOUR MEDICAL CAREER IN FLIGHT.

Discover the thrill of flying, the end of office overhead and the enjoyment of a general practice as an Air Force flight surgeon. Talk to an Air Force medical program manager about the tremendous benefits of being an Air Force medical officer:

- Quality lifestyle, quality practice
- 30 days vacation with pay per year
- Support of skilled professionals
- Non-contributing retirement plan if qualified

Discover how to take flight as an Air Force flight surgeon. Talk to the Air Force medical team today. Call

USAF HEALTH PROFESSIONS

STATION-TO-STATION COLLECT 804-276-0459

AIR FORCE

Lisa Harnum, MD, Pediatrics, 721 West Princess Anne Road, Norfolk VA 23517

Robert E. Hiltz, MD, Internal Medicine, 3813 Jay Avenue, Alexandria VA 22302

Charles E. Hobson, MD, General Surgery, 823 Cabell Avenue, Charlottesville VA 22903

Brian K. Holdaway, MD, Internal Medicine, 6300 Stevenson Avenue, Alexandria VA 22304

P. Arthur Hoyt, Jr., MD, Family Practice, 2248 Criston Drive, Newport News VA 23602

John E. Humphries, MD, Hematology, 408 Westmoreland Court, Charlottesville VA 22901

Maged H. Hussein, MD, Internal Medicine, 5728 Lakeside Oak Lane, Burke VA 22051

Francisco M. Irianni, MD, Reproductive Endocrinology, 151 Linbrook Drive, Newport News VA 23602

Floyd R. Jaggears, Jr., MD, Orthopedic Surgery, 2048 Columbo Avenue, Chesapeake VA 23321

Janice K. Jesse, MD, Pathology, 608 West 24th Street, Richmond VA 23225

Kevin F. Joyce, MD, Internal Medicine, 4949 Manitoba Drive, Alexandria VA 22312

Sam Kazziha, MD, Internal Medicine, Box 381, MCV Station, Richmond VA 23298

Vikram S. Khot, MD, Psychiatry, 350 South Van Dorn Street, Alexandria VA 22304

Michael J. Langley, MD, Urology, 2111 Michie Drive, Charlottesville VA 22901

Joanne E. Lapetina, MD, Pediatrics, 8021 Patterson Avenue, Richmond VA 23229

David A. Lewis, MD, Pediatric Cardiology, 5507 North 36th Street, Arlington VA 22207

Carter L. Lifshutz, MD, Neontology, 217 Bland Street, Richmond VA 23225

Velimir A. C. Luketic, MD, Gastroenterology, 5835-E Willow Oaks Drive, Richmond VA 23225

William W. McDonald, MD, Radiation Therapy, 1440 Kenwood Lane, Charlottesville VA 22901

Scott A. McNamara, MD, Otolaryngology, 2538-B South Arlington Mill Drive, Arlington VA 22206

Ronald H. Malcom, MD, Radiation Oncology, 1015 Holmes Avenue, Charlottesville VA 22901

Daniel J. Mardones, MD, Psychiatry, 632 West Ocean View Avenue, Norfolk VA 23503

Joselyn M. Mateo, MD, Pediatrics, 7447 Foxleigh Way, Alexandria VA 22310

John R. Merten, MD, Family Practice, PO Box 13, Blackstone VA 23824

Mark T. Moore, MD, Obstetrics/Gynecology, 3502-D Kings Point Drive, Richmond VA 23223

James J. Mulvey, MD, Radiation Oncology, 2229 Sun Vista Avenue, Virginia Beach VA 23455

Gary L. Munn, MD, Psychiatry, 4816 Condor Drive, Chesapeake VA 23321

Kevin D. Nowicki, MD, General Surgery, 737-062 Willow Lake Circle, Virginia Beach VA 23452

David S. Oliver, MD, Otolaryngology, 1208 Bobbiedell Lane, Richmond VA 23229

Jeffrey M. Peterson, MD, Family Practice, 89 Saybrooke Court, Newport News VA 23606

Sheryl A.G. Pilcher, MD, General Surgery, 2410-A Barracks Road, Charlottesville VA 22901

John S. Prince, Jr., MD, Internal Medicine, 1468 Brownleaf Drive, Richmond VA 23225

Douglas W. Puryear, MD, Internal Medicine, 2618 Vixen Lane, Richmond VA 23235

Shahed A. Quyyumi, MD, Internal Medicine, 102-A Sunset Avenue, Charlottesville VA 22903

Mark E. Rupp, MD, Infectious Diseases, 6533 Hagueman Drive, Richmond VA 23225

Carole A. Sable, MD, Infectious Diseases, 113 Turtle Creek Road, Charlottesville VA 22901

Donald J. Selig, MD, Psychiatry, 945 Harrington Avenue, Norfolk VA 23517

Weldon F. Shaffer III, MD, Obstetrics/Gynecology, 4689 Buck Run Square, Roanoke VA 24014

Regina Tan, MD, Internal Medicine, 6901 Marlowe Road, Richmond VA 23225

Brian L. Thomas, MD, Anesthesiology, 4506 Thorncroft Drive, Glen Allen VA 23060

Alex B. Valadka, MD, Neurosurgery, 3434 Grove Avenue, Richmond VA 23221

Arnold J. Weil, MD, Physical Medicine/Rehabilitation, 4684 Twentieth Place North, Arlington VA 22207 ■

Help for a troubled friend is only a phone call away.

If you suspect a colleague is experiencing problems with alcohol or drug abuse, don't contribute to the "conspiracy of silence," call The Medical Society of Virginia's Physicians' Health and Effectiveness Committee. A non-punitive approach through rehabilitation *is* an alternative. Your report will be kept confidential. Ask for Jeanne Douglas at MSV headquarters, (804) 353-2721.

STAFF PHYSICIAN

(POSITION #MT2101)

CEBAF, under construction since 1985 in Newport News, Virginia, will be a world-class scientific laboratory centered around a high-intensity, continuous wave electron beam, which will provide a unique capability for nuclear physics research.

We are seeking a Staff Physician to work four hours per day, two days per week to manage an occupational medical program that meets or exceeds all applicable federal, state, local, and medical standards. Collaterally, the incumbent assists management in protecting employees against health hazards and in maintaining a hazard free work place. The incumbent obtains and maintains permits and licenses for clinic operation; establishes a medical records program; conducts comprehensive medical examinations for employees; evaluates and treats work-related injuries and illnesses and provides or oversees emergent patient care when on site. The incumbent also manages subcontracts to provide support services such as radiological and audiological interpretation and laboratory testing; participates in Laboratory environmental health and safety programs; presents an annual Health Risk Assessment report to senior management; and supervises and provides training for a nurse and all department staff.

The minimum qualifications for this position are graduation from an accredited school of medicine or osteopathy and a license to practice medicine in the Commonwealth of Virginia; five years experience in occupational medicine, including at least three years experience supervising an on-site occupational medical program; two years formal training in occupational medicine (Board certification desired). Certification to perform audiometric testing in the Commonwealth of Virginia; membership in State and National Occupational Medical professional associations for at least two years; in-depth knowledge of potential hazards at a laboratory/construction site and diagnosis and treatment thereof including, but not limited to, ODH, radiation, hydrofluoric acid, and high noise; advanced verbal/written communications, interface, supervisory, decision making, conflict resolution, and negotiation skills also required.

We offer a very competitive compensation package and a stimulating work environment.

For prompt consideration, please send resume specifying position number and job title, with salary history to, Employment Manager, CEBAF, 12000 Jefferson Avenue, Newport News, VA 23606.

CEBAF

The Continuous Electron Beam Accelerator Facility

An Equal Opportunity, Affirmative Action Employer

VIRGINIA MEDICAL CLASSIFIED

Virginia Medical classified ads accepted at the discretion of the Editor. Rates to Medical Society of Virginia members: $15 per insertion up to 50 words, 25¢ each additional word. To non-members: $30 per insertion up to 50 words, 25¢ each additional word. Deadline: 5th day of month prior to month of publication. Send to the Advertising Manager, 4205 Dover Road, Richmond VA 23221.

PHYSICIAN'S KIT for Virginia High School League physical exam is once more in stock at Va Med. If you requested a copy when we didn't have any, try again and you'll get it. Write to Physician's Kit, Va Med, 4205 Dover Road, Richmond VA 23221. It's FREE.

EMERGENCY PHYSICIAN—Position available to join progressive 6-member Mobjack Emergency Medicine Associates in the Northern Neck and Middle Peninsula area covering 2 community hospitals managed by Riverside Healthcare Association. Benefits include malpractice and health insurance. Partnership available with additional benefits including retirement plan. Pleasant waterfront communities with nearby metropolitan areas (D.C., Norfolk, Richmond, Williamsburg). Must be BC/BE in EM, FP, PD, or IM. Contacts: Gaylord Ray, M.D., Thomas Young, M.D., Brian Clare, M.D., T.J. Henderson, M.D., James Dudley, M.D., Bobby Stokes, Emergency Department, PO Box 1130, Gloucester VA 23061, 804-693-8899.

EMERALD ISLE NC—Vacation in the "Hidden Treasure of the Sea", 113 Heverly Drive, Ocean Crest, approximately 4½ hours from Richmond; approximately 550 feet to beach. Brand new 4 bedrooms, 2 baths, contemporary home, beautifully furnished & equipped; AC/H; cable TV; phone. Off season 425/week; primetime 525/week. Call collect Lucile Lane 804-798-6510; Lois Rowe 804-752-7859.

HOUSE PHYSICIAN—Richmond, fulltime days, Monday–Friday. Hospital seeking physician who is Board Eligible or Board Certified in Internal Medicine, Family Practice or Emergency Medicine with current Virginia licensure, BLS certification and ACLS certification. Please submit CV to Medical Activities Office, Richmond Memorial Hospital, 1300 Westwood Avenue, Richmond VA 23227, 804-254-6395

RICHMOND, Virginia—Seeking residency-trained physicians for full-time and part-time emergency department opportunities. Two facilities with a combined patient volume of 50,000 plus provides excellent medical and surgical back-up. Double coverage provided during peak periods. Excellent compensation and paid malpractice insurance. Benefit package available for full-time physicians. For more information contact: Betty Albrecht, Emergency Consultants, Inc., 2240 S. Airport

OUR HOME SALES ARE ON THE UPSWING.

Bert Hodson

Golf Course Open - Public Invited!
Call (804) 739-8800

Swing by the 500-acre golf course community of Birkdale, and you'll see why so many people wouldn't live anywhere else. Each of our homes is a perfect example of quality craftsmanship, whether traditional, Victorian, or contemporary.

Over half of them offer views of the lake and fairways. And they all offer access to the tennis, swimming, and tree-lined paths for biking, walking, or jogging.

Of course, one of the main attractions is our Dan Maples-designed championship golf course. A full-service practice range and our daily fee golf course will be open for your inspection, along with our homes.

Call us at our Information and Sales Center—(804) 739-0301 today. Here at Birkdale, the quality of English country living will always be in full swing.

Birkdale

Directions: Drive 2 miles on Rte. 360 west of the 288 Interchange, then turn left on Winterpock Road for one mile to Birkdale.

EQUAL HOUSING OPPORTUNITY

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

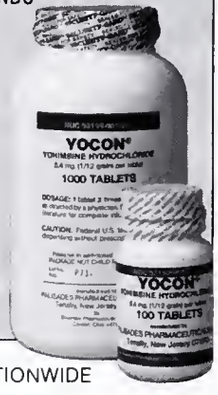
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

PALISADES PHARMACEUTICALS, INC.
219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

Road, Room 40, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

WINTERGREEN RENTAL—Cliffs Condominiums, two bedroom, two bath, overlooking entire Wintergreen village near top of the expert slope. Rates are substantially less than through Wintergreen's front desk. Call Thomas Shuttleworth at 804-431-3100 or write 2809 S. Lynnhaven Road, Virginia Beach VA 23452.

APPRAISALS & SALES—The specialists in on-site practice valuations and transfers to physicians, hospitals and investors. Please contact: Ed Strogen, Fulton, Longshore & Associates, Inc., 527 Plymouth Road, Suite 410, Plymouth Meeting PA 19462; 215-834-6780 or 1-800-346-8397.

WASHINGTON DC—Internist BC/BE to join young, busy internist in Virginia suburbs of Washington DC. Strong commitment to primary care required. Excellent salary, benefits and partnership pathway. Send CV and cover letter to VA Med Box 132, 4205 Dover Road, Richmond, VA 23221.

FAMILY PRACTICE on Chesapeake Bay—Owner retiring. Start enjoying medicine again. Four day work week, no HMO, PPO, or Medicaid. Join owner and take over practice in one to two years. Send reply to Va Med Box 133, 4205 Dover Road, Richmond VA 23221.

POSITIONS AVAILABLE in Virginia Beach and surrounding cities—Sentara Medical Care Centers, a subsidiary of Sentara Health Systems, Virginia's premier health care network, are seeking BC/BE physicians to staff its Centers. Family practice opportunities also available. Flexible hours, competitive compensation package, incentive programs available. Excellent recreational, cultural, and educational area. Send CV to Gail Billups, Sentara Medical Care Centers, 22 Koger Executive Center, Suite 202, Norfolk, Virginia 23502 or call collect 804-466-9187. An Equal Opportunity Employer.

HOLTER RECORDERS provided to physician's offices at no charge. Virginia Heart Institute's services includes scanning, analysis and interpretation of Holter 24-hour ambulatory recordings. Call 804-359-9265 or in Virginia 1-800-468-1030.

FARMVILLE, Virginia—Seeking full-time and part-time physicians for hospital located 1 hour west of Richmond. Excellent compensation, full malpractice insurance coverage, and benefit package to full-time staff. Contact: Betty Albrecht, Emergency Consultants, Inc., 2240 S. Airport Road, Room 40, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

PHYSICIANS WANTED—Family physician or internist for office and hospital practice in the greater Richmond area. There is also an opening for a semi-retired physician for part-time work. Inquiries held strictly confidential. Send CV and financial requirements to Va Med Box 131, 4205 Dover Road, Richmond VA 23221.

UNSECURED LOANS for physicians. Call Dr. Gerald Sacks, 703-751-3226.

Physicians wanted for leading practice

Prestigious national group specializing in the treatment of venous disorders has exceptional opportunities in major metropolitan areas throughout the United States. We are in need of physicians trained in internal medicine, surgery or who have a broad based medical background to establish and direct a clinic as well as practice our state-of-the-art treatment techniques. We will provide complete training in the latest proprietary techniques of treating venous disorders. We offer an outstanding compensation package in the six figure area along with malpractice insurance and health benefits. Additionally, we offer a 40 hour work week, no weekend hours and freedom from beepers. You also won't have to worry about soliciting for patients or fighting insurance companies.

This is an outstanding opportunity for professional and financial advancement. If you are motivated to build a rewarding practice with the leader in the treatment of venous disorders, send your curriculum vitae to:

Medical Director

Vein Clinics of America

2 TransAm Plaza Drive, Suite 450
Oakbrook Terrace, IL 60181

DIRECTORY OF ADVERTISERS

BioSystems Partners	243
Birkdale Realty	275
Continuous Electron Beam Accelerator Facility	274
Clements & Company	268
Elcomp Systems, Inc	271
Health of Virginia	242
Insurance Corp. of America	244-5
Eli Lilly & Company	240
The Management Company	227
Merck Sharp & Dohme	Covs. 3,4
Medical Protective Company	232
Palisades Pharmaceuticals	276
John P. Pearl & Associates	231
Peoples Drug Stores	263
Reed and Carnrick	237
Richmond Headache Center	241
Roche Laboratories	238
The St. Paul	254
Sentient Systems, Inc.	225
Sheppard Pratt Hospital	236
United States Air Force	272
United States Army Reserve	Cov. 2, 239
University Center for Addictive Behavior	268
Vein Clinics of America	277
Virginia Insurance Reciprocal	228-229
WMI Medical Waste Services	277

Specialists in Handling Medical Waste

- HOSPITALS
- DENTAL
- LABS
- VETERINARY
- CLINICS
- PROPER STORAGE
- TRANSPORTATION
- DISPOSAL
- DOCUMENTATION
- CONSULTATION

CALL 1-800 *MED-WAST*

WMI Medical Services

The Medical Waste Solution.SM

1405 Gordon Avenue • Richmond, VA 23224

A Service of Waste Management

WHO'S WHO

New dean of Eastern Virginia Medical School is **Dr. James E. Etheridge, Jr.,** who had been serving as interim dean since July 1 of last year and before that had been professor and chairman of the department of neurology, specializing in child neurology. His appointment as the school's fifth dean was announced by Edward E. Brickell, EdD, president of the Medical College of Hampton Roads, the administrative body for EVMS.

A native of Norfolk, Dr. Etheridge received both his bachelor's degree in English (1951) and his medical degree (1955) from the University of Virginia, where he also trained in pediatrics. He undertook advanced training in pediatric neurology and neuropathology at the National Institutes of Health, the Mayo Clinic, and Northwestern University School of Medicine and completed two fellowships in clinical electroencephalography, one at the University of Wisconsin School of Medicine, the other at Mayo's. He joined the EVMS faculty in 1974 after teaching assignments at his alma mater and at the Univesity of North Carolina, Chapel Hill.

As dean, Dr. Etheridge will also be provost of the Medical College of Hampton Roads, the next most senior post to the presidency.

The elections of these twelve new component society presidents have been reported to VIRGINIA MEDICAL since the first of the year:

Albemarle County, **Dr. Howard A. Montgomery**, Charlottesville.

Alexandria, Dr. **Frederick M. Stier**, Alexandria.

Arlington County, Dr. **Philip M. Borges**, Falls Church.

Danville-Pittsylvania, Dr. **Victor Oberheu**, Danville.

Fairfax County, **Dr. Brantley P. Vitek**, Annandale.

Loudoun County, **Dr. Thomas J. Gates**, Leesburg.

Mid-Tidewater, **Dr. Frederick S. Arnold**, Gloucester.

Newport News, **Dr. Helmuth W. Trieshmann, Jr.**, Newport News.

Northern Virginia, **Dr. Marc E. Read**, Woodstock.

Prince William County, **Dr. Jared E. Florance**, Manassas.

Roanoke Valley, **Dr. Samuel J. Williams II**, Roanoke.

Southside Virginia, **Dr. Joseph L. Crosier**, Petersburg.

Tri-County, **Dr. Carlos Pinto**, Suffolk.

For his "outstanding contribution to the Medical College of Virginia Alumni Association," **Dr. Alton R. Sharp, Jr.**, Richmond, was selected by the Association's Medical Division for its 1990 Caravati Award. The presentation was made at a dinner and reunion in Richmond.

Dr. William C. Andrews, Jr., Lynchburg, has been inducted as a fellow of the American Academy of Orthopaedic Surgeons.

Fellowship in the American College of Surgeons has been conferred on **Dr. G. Andrew Gehrken, Jr.**, Martinsville.

Dr. Steven M. Zimmer, Arlington, has been installed as president 1989-1991 of the Virginia Thoracic Society.

Dr. Harvey V. Lankford, Richmond, recently received a national recognition certificate from the American Diabetes Association for his outpatient diabetes program, one of only four such programs in the country to receive the designation.

Taylor Dabney

State Visit **Virginia's new Secretary of Health and Human Resources invited the Medical Society of Virginia's President to drop by Capital Square in Richmond for a visit, and they are pictured above, Secretary Howard M. Cullum on the left and Dr. William H. Barney on the right, when Dr. Barney was in Richmond for the Teen Health Forum described elsewhere in this issue. Their conversation was fruitful, and Dr. Barney returned the Secretary's hospitality by inviting him to meet with MSV officers, councilors and selected committee chairmen to discuss urgent medical matters in Virginia.**

VASOTEC®

(ENALAPRIL MALEATE | MSD)

VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor

Warnings: *Angioedema* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed, caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General. Impaired Renal Function.* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia. Elevated serum potassium (>5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions*.)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients.

Angioedema. Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension. Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension. Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release. The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy – Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION. The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances; atrial fibrillation, palpitation.

Digestive: Ileus, pancreatitis, hepatitis (hepatocellular or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, hyperhidrosis.

Special Senses. Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, tearing.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgias/arthritis, myalgias, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema. Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol%, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension.* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions*.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment. The usual dose of enalapril is recommended for patients with a creatinine clearance > 30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤ 30 mL/min (serum creatinine ≥ 3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure. VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions*.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects*.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Patients with Heart Failure and Renal Impairment or Hyponatremia. In patients with heart failure who have hyponatremia (serum sodium < 130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, *Heart Failure*, WARNINGS, and PRECAUTIONS, *Drug Interactions*.) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information, Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486 J9VS61R2(819)

MSD
MERCK SHARP & DOHME

THERAPY THAT MAY BE AS SILENT AS HYPERTENSION ITSELF

VASOTEC is generally well tolerated and not characterized by certain undesirable effects associated with selected agents in other antihypertensive classes.

VASOTEC is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

A diminished antihypertensive effect toward the end of the dosing interval can occur in some patients.

For a Brief Summary of Prescribing Information, please see the last page of this advertisement.

FOR MANY HYPERTENSIVE PATIENTS
ONCE-A-DAY

VASOTEC®
(ENALAPRIL MALEATE | MSD)

UCSF LIBRARY
SERIALS DEPARTMENT
257 MEDICAL SCIENCES BLDG
SAN FRANCISCO CA 94143-0840

Copyright © 1990 by Merck &

UC San Francisco LIBRARY
UNIVERSITY OF CALIFORNIA

579253

3 1378 00579 2539

UC San Francisco LIBRARY